PLANNING FOR CHILDREN IN NATIONAL DEVELOPMENT

by

David P Haxton
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It is not necessary to wait until poverty is overcome completely before taking action on a policy for children. Rather, an imaginative policy for children and its planned execution must be an important plank of any realistic anti-poverty programme.

I must congratulate the Ministry of Plan Implementation on the idea of celebrating Sri Lanka's 50th anniversary of the coming of the franchise by focusing on the rights and needs of the citizens of tomorrow. It is with pleasure that I accepted the invitation to participate in this Seminar. I see it as part of your thoughtful preparation to enter the 21st century.

Sri Lanka's progress

Before I come to the topic given to me, I would like to pay a tribute to the strides taken by Sri Lanka in caring for its children. These are exceptional by the standards of the developing world—be it the high literacy rate of 78.5 per cent (1971) or the low infant mortality figure of 37.1 for 1000 live births (1978). There is more to these indices for social development than meets the untrained

eye. Sri Lanka has shown how much human progress can be achieved on how little economic wealth—given the informed commitment of the nation to its young. What is even more reassuring is the widely shared concern that a lot more must and can be done for children before we can feel that we have done our duty by the new generation. Despite the gains in a few directions of development by some countries, the basic needs of the majority are, by and large, yet to be met. That includes the majority of children as well.

It is in this perspective of planning for children, that a stable and progressive balance of economic as well as social development has to be achieved. For neither can be promoted singly. It is a function of national planning to make this composite aim feasible. Planning for children is another name for planned development of the human potential of a country. Unfortunately this is not yet happening to any decisive degree of success in most developing countries—even where the planning process has acquired institutional strength. I shall try to go into the causes of this situation and what may be done to alter it.

Planning priority for social development

The pre-occupation with the gains of economic growth, to the relative neglect of human development, has its roots in the pre-independence history of the developing world. But these continue to be nourished by several adverse factors that are controllable by our attitude to them. For example, economic growth looms large on the planning horizon because hard information on the economy is regularly available, investment in physical assets is rated high in return, progress in their acquisition is visible and measurable. Not so today the gains in social or human development through child and mother care, health and nutrition services, education, water supply and sanitation, social orientation and support. Balance sheets do not make their periodic appearance in these fields. Measurement of progress is not easy. And when it is possible the indices are too crude and take time to work out. If these are among the reasons why development of human resources receives low planning priority—and also gets the axe in times of tightening budgets—social scientists and statisticians must help to tackle them by devising

suitable measuring tools, by establishing promotive and monitoring procedures, on a par with economic development.

Attitudes must change

More importantly, we have to change our habitual attitude to investing in the human potential. Studies over the past decade and more have shown that the rate of economic return in education is, for exmple, higher than that in physical assets like factories and dams. Primary education is a more gainful investment proposition than higher education. Community health projects yield a higher economic return than sophisticated hospitals. It thus makes economic sense to give priority to investment in children. Which is of course not to say that we need no factories or hospitals, but the scale of priority needs to be re-ordered.

Even on the part of those who concede that investment in the young is 'productive', there is still a tendency to regard the return on the investment as too long-term to be attractive enough. In fact the term is no longer than for a hydro-electric plant or a steel mill.

Acting early enough

To give an illustration in this international year of the disabled persons, nothing is costlier to the nation than to expose a child to the risk of physical or other impairment, let it escalate into an irreversible disability and then to look for resources for rehabilitation that can never be adequate.

What is true about preventing disability equally holds in promoting development. We have to act early enough. The foundation of growth and development through the years of school age, youth and adult life is laid in infancy and early childhood, indeed even earlier, in the womb. Each stage of life is a preparation for the next. If the early years suffer relative neglect—as they often do—it will not be easy to make up later for the lost human potential.

Dimensions of planning for children

We may now look at another set of dimensions of planning for

children. Their growth needs deserve a different approach than to adult needs. Their nutritional requirements call for special attention. They are more vulnerable than adults to changes in family environment and the available pattern of food and other basic needs, to infection and illness. And what the family and society now do to the children determines their personality, the quality of their adult life and their contribution to society.

The needs of children vary according to their age group. And our interest in their growth must start when life begins and must therefore include the mother rather prominently. There are then the segments bypassed by, or marginalised from, the process of development. Again, the children in the village have problems somewhat different from those in the town, or those of migrant parents. Thus, the global policy on children would need changes and adjustments in keeping with differences in age, income, geography, and culture ; or, for that matter, with the strains in the economy and the vagaries of the development process.

Also, most of the services required by children reach them indirectly—depending on the kind and quality of services to which their family and community have, or do not have, access. And these services are the responsibility of different sectors operating under different ministries. A dozen such ministries could be involved—from public works to justice—in matters impinging on the life and development of the child. The perceptions of these ministries on the same children may differ for reasons that may be legitimate in a narrow sense. So too their policies and priorities. Making these services converge at the level of the family and at the same time cannot therefore be assumed as a certainty. It can happen only through planned co-ordination and effort.

Awareness

At the levels of policy formulation, planning, decision-making and execution there has to be greater awareness of the needs of children and a greater assurance that there are possibilities of meeting them. Generating this awareness is an important, if largely unaccomplished, task for those interested in development of children. The mass media as well as government channels must assume this responsibility on a continuous basis.

Co-ordinated application

Closely related is the problem of bringing experience and knowledge from different sources to bear on the processes of decision-making, resource application and result achievement in relation to the policy and programmes for children. This again remains, unfortunately, a substantially unsolved problem in most countries. The solution must include locating and mobilising talent from government ministries, academic and training institutions, local self-government bodies and non-government organisations. We must also train our ear to listen to and learn from the people.

The problems besetting children in the developing world are such that death may overtake them before they have a chance. Improper or inadequate care during the early years may deny them through the rest of life their full potential. Poverty is of course the main contributing factor to this situation and we have to tackle it. But it is not necessary to wait until poverty is overcome completely before taking action on a policy for children. Rather, an imaginative policy for children and its planned execution must be an important plank of any realistic anti-poverty programme.

Supportive measures

I shall now touch on some of the supportive measures called for if planning for children is to fulfil its aim. A primary need here is reliable information on the situation of children, the condition of their life, the nature of their special problems. As these variables change continuously, for better or for worse, the process of information gathering and analysis too has to lend steady support to the policy-making function. Statistical projections should be used to present alternative scenarios, so that a choice of strategies is open to the decision-makers.

There is another aspect crucial to the success of development for children, and that relates to the means and methods we would press into its service. The less developed a country the greater its need for financial resources and the smaller its capacity to find them. But no country is too poor to take a minimum care of its children. It is in this perception that we in UNICEF have consistently

pleaded that :—

—more financial resources must be diverted, than is usually the practice, for application to development of children—as a matter of stronger commitment to the youngest generation ;

—raise the level of resources by seeking peoples' participation in the social as well as economic development—as a democratic policy of viable decentralization.

—get more out of whatever money is spent by improving the organization and strengthening the linkages of the delivery of the different services—as a line of strategy and technique.

Feasible solutions

Scientific and technical advances have greatly increased the means for reducing the contrast in the fate of children born in poor parts (and families) of a country as opposed to those born in better-off parts (and families) of the country. Alternative methods of organizing and delivering services are known and can be applied. For example, safe and adequate supplies of water can be provided inexpensively and effectively. Perhaps a revision of agriculture and nutrition policy would help to reach food adequate to the diet of children and closer to home at lower prices. Immunization against childhood diseases is cheaper and easier than before. Literacy to mothers and fathers is today within the scope of practical support. Feasible solutions are available to most problems of children. In several cases a choice of alternative delivery systems is also possible. These are positive factors in aid of planning for children.

Some relevant issues

The national policy for children will have to face up to a number of related issues, which may appear intractable in the absence of a coherent policy. Today I shall only remind you of them by providing a selective sample.

—The policy for children cannot escape a direct and close relationship with food and nutrition policies. Malnutrition is

unlikely to disappear in the course of normal per capita income growth, or for that matter through higher aggregate food production. Specific nutritional policies are needed to translate the potential offered by better income and food availability into better nutrition. Action to end the deprivation of vulnerable groups, and consumer education, are examples of possible and necessary steps. There are then the anti-nutritional side-effects of certain development trends of urban or exotic origin. The decline in the traditional practice of breast-feeding and the neglect of good weaning practices are typical instances of unintended 'development'.

—There are people who argue that a reduction of infant and child mortality (which is a basic element of any policy for children) aggravates the pressure of population growth. The superficiality of this logic has been established by several studies which reveal that the strongest motive for responsible parenthood lies in the aspirations of parents in the health and advancement of each child. This perception could be related, in a purposeful way, to a policy for children by making the spacing of pregnancies a supportive aspect of that policy. It is important to foster, through a national policy for children, the linkage between responsible parenthood, family planning services and maternal-child care.

—There are positive as well as negative aspects of the impact of modernisation on children. The responsibility is usually shared by the family, religious institutions and the state to meet this situation, on behalf of children. But it is a function of a national policy for children, especially in its components relating to education and training, to outline the nature of the needed response.

—Literacy is one of the widely desired fruits of development. The national policy for children must go deeper to mould the quality of schooling and to promote the national cultural tradition which may be in danger of being overwhelmed by trivial aspects of imported cultures.

I hope I have said enough to show that a policy for children can only follow—and not precede—a thorough study and analysis of the situation of children and the best means—direct or

indirect—of helping and developing them. Ideally this excercise should allow participation by all segments of the national community. And prevailing systems and methods should be subjected to review in the interests of children. And the review should cover the legal, political, administrative, financial and management structures, so that meaningful changes could be introduced in the national development plan. This process calls for a constantly working mechanism geared to well-defined goals and a flexible approach to meet the differing needs in different parts of the country or segments of the population. It should also lend itself to in-course correction.

A place for children in planning

The cluster of factors that I have mentioned argues the case, rather strongly, I think, for an organism at the core of the planning structure with the prerogative, authority and competence to formulate national policies and plans, select strategies and lines of action, and ensure budgetary backing and effective spending—on behalf of children. This appears necessary if the needs of children are to be related practically to the aims of national development.

What I have sketched provides you with but a glimpse of the possibilities. These are not purely theoretical. Some country or another has proved that these are achievable. Sri Lanka is itself a good example in many respects.

Time is not on our side in matters relating to children. If the social segments within a country pull together, bringing the government, private sector. voluntary agencies, community organisations and the various professions firmly on the side of children, there will be room for cautious optimism that a movement for human development may pick up across the developing world, in a decade or two. This will not happen autonomously ; we will have to plan for it. The message I would like to leave with you today is that together we can make it happen.

Reprint of a statement by Mr. David P Haxton at the Seminar on the Changing Needs of Children in Colombo 7—10 September 1981

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DEVELOPMENT CO-OPERATION IN THE 1980's

by

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Global goals have to be translated into feasible national goals for human development. Development plans should have a basis in a comprehensive analysis of the situation of children. And the priorities of aid must be adjusted to the emerging national goals.

I am honoured to have the opportunity to report to this meeting on the UNICEF perceptions of the situation of children in the environment of today, and on our approach, through the third Development Decade, to this global human condition.

I shall not attempt, in the limited time at my disposal, to draw, in any detail, a statistical portrait of the world's children—or of the billion of them in the developing countries—but only touch on a few salient facts to show that the future may only be a re-run of the grim past unless the concept, pattern and means of development are consciously altered world-wide, in favour of those who stand in the greatest need of it.

There is, let me add, reasonable hope that such a change can at last be brought about in the common interest. And this hope derives mainly from the greater public awareness of the international community, consequent on the attention focussed by,

among other events, the International Year of the Child, the International Drinking Water Supply and Sanitation Decade and the International Year of Disabled Persons.

Development Strategy for the 1980's

It was only natural that the UN General Assembly could reach a consensus, in September 1980, on the New International Development Strategy, defining development as an integral process in which the objectives of economic, social and human development converge in support of specific goals relating to elimination of hunger, primary health care for all, universal primary education, and a sharp reduction in infant mortality by the end of the century. UNICEF is conscious of its modest role and resources as a development promoter. Yet we feel that the development strategy for the 1980's is a vindication of the basic services strategy evolved by UNICEF.

This approach emphasises the development of the human potential through community participation and responsibility. We believe that, with policies aimed at satisfying the basic needs of the people the developing nations could overcome many of their disadvantages within one generation. But this would mean a modification of the pattern of growth of the developed countries as well as of the richer segments of impoverished societies. While the worst aspects of world poverty can be overcome, the sustainability of the developed economies is dependent on this happening. This is the perspective for development co-operation in the 1980's which UNICEF shares and looks forward to functioning in.

There can, however, be no discounting the magnitude of the effort needed in the coming years, nor indeed of the economic crunch through which we have to make our way. I shall briefly refer to both these aspects.

Two Development Decades

There is no mistaking the outcome of the attempts over two Development Decades to alleviate poverty and distress through economic growth. The gap between the rich and the poor of the earth is actually widening. There has been stagnation, or decline,

in the living standards of the poorest 20-40 per cent in many developing countries. A typical industrialised country has 10 times the per capita income than its less developed counterpart and more than twice the level of literacy. The comparative infant mortality rates are 20 and 120. The average protein intake, per day per person in the developed world, is double that in the developing world. There is one doctor for every 680 persons in the former, for every 3490 persons in the latter. The life expectancy is 71 years and 52 years respectively. Inequalities between peoples, as well as within most nations, are becoming sharper.

The consequences of this situation are even more adverse for children. Of the world's 1.5 billion children, four-fifths live in the developing countries. Among them about 600 million suffer from poverty. Some 350 million children do not get enough to eat for the minimum calorie requirements. And the main reason for this is that the international and national economic systems work, in effect, to their disadvantage. Less than 2 per cent of the world's cereal production would in fact suffice for basic calorie needs. In rural India, where 80 per cent of the population live, the per capita monthly expenditure is a little over Rs. 50, four-fifths of which is spent on food. Given the income distribution, more than half the population must fall below this average.

Some 15 million children below five years die every year in the developing world. Half of them are killed by malnutrition or by diseases fuelled by it. Disabilities of one kind or another afflict about 150 million of the world's children, four-fifths of them, mostly from poor families, are in developing countries. Another estimate puts the number of children in these countries, suffering from persistent and socially handicapping mental disorders, at 5 to 15 per cent of the total—that is a 100 million, more or less. About 18 million children in India alone, have their vision impaired due to dietary deficiency in Vitamin A. Every year around 250,000 children go blind the world over, from much the same cause.

Roots of Non-development

My point in remembering these samples of needless suffering is that the world community is doing less than it can, less than it must, to stem the creeping calamities in poor societies. If an

earthquake somewhere claims the lives of 100,000 children in the next three days, the international community would undoubtedly respond promptly and massively. In fact, during the next three days that is precisely the number of children who will perish avoidably as a result of hunger, thirst and disease. Our attitudes need obviously to change.

The trends and causes that I have touched on are not accidents that have come upon us unexpectedly. They have been in evidence for some years now, and there are inelegant terms like "militarism" and "consumerism" to denote the forces that propel them. Everyone knows the world spends over a hundred million dollars a year per capita on weapons of war, but spares too little to end child suffering. Every year Americans spend on cigarettes about 3,000 times as much as the UNICEF annual budget of around 300 million dollars.

This apart, the outlook for balanced development is not helped by the presence today of concurrent economic crises : the slowing down of growth across the world, the soaring costs of energy, the rising graph of unemployment, the danger of the eco-system being pushed out of balance and, as daily experience shows, the relentless upward spiral of prices of even essential goods. The burden of all these falls unequally between the fortunate few and the numerous poor within countries and in the world overall. There is even the tendency to shift the burden from the present to the future, as is the case when we deplete non-renewable mineral resources for current consumption.

Beyond Economics

These are problems that are generally categorised as economic as they relate to the rapid consumption of resources and contrasting standards of living. But, surely, the solutions have to transcend conventional economics to relate economic aims to wider social goals. The direction and speed of growth will need to be changed and adjusted, and the support of the political will summoned, to achieve the goals of society as a whole. Development needs to be redefined, not just in terms of economic growth in the aggregate, but also in terms of social cohesion and justice, political awareness and empowerment, cultural regeneration and

quality of life. The means and mechanics of development too will need to be reshaped—appropriate technologies, systems of education and health, the legal and political processes, the fiscal and monetary structures. Such is the nature of the challenge of development and the test of co-operation for it.

This is the context in which more and more people agree on the *need* for a set of complementary strategies to be applied on a global scale and in a concerted way—increasing employment, meeting basic needs, reducing inequalities of income and wealth, and of status and opportunity, raising the productivity of the poor. For this to happen, economic inputs have to be reinforced by social inputs like education, nutrition, primary health care, water supply, clean environment. The focus thus shifts from linear economic growth to balanced socio-economic development. And the priority should naturally go to developing the human resource from its earliest stage. This is a perception deeply shared by UNICEF.

There is, likewise, a growing consensus on the *means* of human development—education for self-reliance, and self-respect; participatory communication to identify and articulate the essential needs of the community ; community participation, in progressive stages, for organizing and maintaining basic services; the mutual support and consequent enhanced effect of different services like nutrition, health, sanitation and education; social preparation for relevant economic activity and equitable absorption of the yield. UNICEF fully subscribes to this comprehensive approach to development with its focus on human growth. In our parlance, it is called the 'basic services strategy'. It was approved by the UN General Assembly in 1976.

Basic Services Strategy

The relevance of this strategy to the situation of children is obvious. The basic needs of children are known—safe water, nutritious food, clean environment, health care, basic education. These in turn call for maternal as well as child care; local production, storage and consumption of more and better quality foods; education of the mother; simple technologies to lighten her daily tasks; opportunities to augment family incomes, especially the earnings of women; essential community facilities like water

supply and sewerage. It is the understanding of UNICEF that services of this kind for local communities cannot be generated from outside on a viable basis. They can be established and maintained durably and on the needed scale only if the community wills to have, and strives to keep going, these mutually supportive facilities. This means that the community for whom the services are meant is involved from the outset in identifying its needs, deciding priorities, planning the sequence of stages, selecting the community workers, and generally controlling the range of activities in a democratic way of functioning. The productive use of local human and material resources can keep recurrent costs down to a level the community can afford. In such a scheme of things, the role of government as well as non-government agencies is to assist in meeting the capital costs and in providing training and technical and logistical backing. The UNICEF mandate is the well-being of children and one of the main means of fulfilling it is the basic services strategy. UNICEF, in its turn, must be enabled to maintain and accelerate the pace of progress in this direction.

We believe the basic services strategy answers, in major part, the economic quandary of governments concerned about being financially unable to extend the conventional services to all the people. It faces up to the problem of professional disinclination to go and live or work among people in villages and urban slums. And finally, it preserves human dignity by making people, in their families and communities, feel that they can assume the responsibility of looking after their basic needs—given the kind of knowledge that emancipates.

The commitment of UNICEF to an integral concept of development has been field-tested by its own practical experience over three decades of co-operation with governments, international organisations, non-government bodies, communities and individuals. Some of the premises supporting the UNICEF approach to development are also borne out by national examples. For example, Sri Lanka, which has a per capita GNP of less than $200, has already surpassed the 'new' targets for 2000 A.D. With a literacy rate of 80 per cent, an infant mortality rate of less than 50 per thousand live births and a life expectancy of 68 years, Sri Lanka has shown how much human progress can be achieved on how little economic wealth. Contrarily, many parts of India, where massive

investments have been made over the past three decades in irrigation and industry, sophisticated hospitals and large universities, the physical quality of life of the majority of the people has remained largely untouched.

UNICEF fully shares the view that it is very unlikely that there will be sustained progress on either the economic set of issues, or the basic human needs set of goals, unless the two go together. A notable translation into action of this perception is the UNICEF support for area-specific integrated development—to which, I am glad to report, nearly all South Asian Governments have begun to subscribe. This policy implies devolution of authority to the district and lower levels. The UNICEF response entails a corresponding organizational capability to link up, promptly and effectively, with the local level. While sectoral assistance continues, cross-sectoral area development, concentrated in backward regions, is increasingly the pattern of UNICEF co-operation. This will, we believe, accelerate the rate of improvement in the well-being of children.

In this task, UNICEF capacity has to be selectively strengthened. As governments in both hemispheres must learn to do more with less—given the current economic pressures—UNICEF too will have to make more effective use of its resources in meeting the most essential needs children. Its network of staff, 80 per cent in developing countries, is a unique resource, within the UN system, for contact with operational levels of national development effort. Its community-based cross-sectoral approach enables it to focus on low-income groups in their social contexts. These capacities are greatly needed to strengthen the national investments in social programmes, which still remain relatively meagre.

The UNICEF responsibility as the lead agency for children, in consequence of the International Year of the Child, is a natural extension of its mandate, but it entails action in aid not only of the survival of the seriously endangered, but improvement of the conditions and opportunities of all children, in developing and industrialised countries alike.

UNICEF is at work in 110 countries which have, between them, 1286 million children. South Asia presents, numerically, the

largest challenge to UNICEF capability, though qualitatively the most depressed situation for children would be in the African interior. Our plan of action for the 1980's has been worked out in detail for the first three years, 1982-1984. Realistic but ambitious proposals will be coming up before the Executive Board next month. In India, for instance, the UNICEF budget will have doubled by 1983 from the level of 29 million in 1979 (which itself is a leap from 12 million in 1975). It is therefore natural for us to hope that donor governments, host governments and funding entities would, in the coming years, significantly step up their contributions so as to augment the resources applied to child-oriented programmes.

Global goals to national plans

The task then is to translate the global goals into feasible national goals and to achieve them in the measurable future. UNICEF is committed to assist governments to formulate and pursue national goals relevant to child development. In this context, we believe that each government should be encouraged to prepare a comprehensive situational analysis of children, so that development plans can be based on it. We also feel that it is necessary to take a fresh look at bilateral aid to adjust and match the priorities of aid with the emerging national goals. Such an exercise is necessary, fairly urgently, in order that :

—a total view can be had of the tasks that need to be tackled

—international agencies can identify the precise areas in which they can help and also relate such help to the allied requirements in other areas

—the development tasks can be quantified in economic terms and planning can come to grips with costs and benefits.

UNICEF is able, willing and eager to co-operate with donor agencies by sharing with them its information service and by joining in the preparation of particular projects. The participation of UNICEF in project formulation could help :

—strengthen the relationship of confidence between the

donors and UNICEF

—assure that the priority for young human development is not lost sight of

—increase the availability of resources for intelligent application to delivery of basic services.

We in UNICEF would welcome any step that would enhance the impact of our effort, as spelled out in the medium-term work plan. Indeed, the donors have every right to insist on proof of productivity for UNICEF expenditure.

Not by money alone

I would like to add however, that it is not by monetary contributions alone that children can be helped. International co-operation at government and public levels can be immensely productive in promoting simple but appropriate technologies—like mothers' milk for infants. Here I need not go into the reasons why breastfeeding is almost everywhere declining in favour of bottle-feeding. But the Draft International Code of Marketing of Breastmilk Substitutes will have to be taken up at the national level—in both developing and industrialised countries—for effective regulatory action, through the force of organised public opinion as well as of the law. Governments in the North as well as the South need to be persuaded :

—to support and vote for the Draft Code coming up at the World Health Assembly next month; and secondly,

—to take effective follow-up action at the national level.

There are, as I mentioned earlier on, numerous other policy aspects that need to be promoted at government levels in the interests of child development everywhere.

May I conclude by saying that once we are agreed on the need for a new pattern and redesigned tools of development, co-operating for it becomes easier.

Reprint of the statement by Mr. David P. Haxton to the Donors' Meeting on 29 April 1981 in Colombo

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CHILD HEALTH : WHAT THE FAMILY CAN DO

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There is scope for a range of actions a family can take to safeguard its health, even in conditions of serious economic inequality and social discrimination. These actions are mainly promotive and preventive but to an extent even the curative function can be fulfilled, given the right kind of information.

The family is the first defence for a child in any society. This has been a working principle of UNICEF from the beginning of our involvement and for over 35 years. The theme of this Seminar thus coincides substantially with the UNICEF approach to child health. We would like to learn from, as well as share our experience with, the distinguished delegates to this Asian meeting. It was therefore with much pleasure that I accepted the invitation of the president of the Asian Union of Family Organizations to participate in this quest to "rediscover" and reinforce the capabilities of the family in protecting and promoting the health of its members : the well-being especially of those members who need such attention most, namely children.

There are four channels of help to children. The *first* is the family in which the child is found. The *second* is the community in which the family is located. The *third* is the system of government

services available to both. The *fourth* is international and other outside assistance.

Thus, I hope to show that there is, in the Asian context, no credible alternative to the family—yes, even a low-income family —assuming the first-line responsibility for looking after much of its own health. Indeed, families are discharging that responsibility as best as they can, and against almost impossible odds. And they do not have to be prodded in this task—any more than a mother has to be motivated to care for her child. You will find that, among the poor, the concern for the well-being of one another is so strong that it extends beyond the immediate family. How else do the unemployed survive in the absence of social security? It is a different matter if the capability of a family does not match its concern. It is the capability of a family which needs to be enhanced at the same income level with some marginal assistance from the rest of the society.

First, let us consider the inevitability of people, in their families and local communities, having to find answers to most of their own health problems. Many Asian countries began their career of political independence with excellent blueprints for basic health services for all the people. A few decades later, we find that a majority still does not have access to these services, even where progress has been made, as in several countries, to reduce mass disease. Is the lack of rapid progress due only to lack of finance? I doubt it. It may however be related to lack of political will coupled with a primary health care approach.

The health problem has been 'successfully' medicalised—to the detriment of the generality of the people. The medical profession and the drug industry are now at the centre of the health stage. And those who need health services are at the periphery. Modern medical science is all to the good but, clearly, its marvels, or benefits, do not reach most of the people.

Let me cite an example. A survey was recently conducted by a welfare organization in a few semi-urban areas in a major capital city, with the help of the local Medical Association. Of the 600 children of pre-school age covered, *not one* was immunised adequately with the DPT and polio vaccines. Only two were protected

against measles. The majority went without immunization of any kind. This, in spite of all these children attending government-aided nurseries, in spite of government grants for periodic visits by a medical professional, in spite of there being a primary health centre in the neighbourhood. It is not fair to these children that doctors should wait for an epidemic to feel impelled to spring into humanitarian action. Rather, if the parents of these children are made aware of the danger of not immunizing their children and also the easy availability of the vaccines, they would themselves demand the service, which is within the competence of a health worker to provide. Thus, I suppose, the first thing a family should be—is "aware". Aware of need ; aware of choice ; aware of the value of preventive vaccination.

Luckily, I do not have to labour this point. Some enlightened leaders of the medical profession are themselves rethinking the social relevance of medical science. And change comes surely when it comes from within. It is today acknowledged that, as private medical practitioners overflow from cities into villages, the cost to the villager is higher by about ten times for the health-related jobs which the local people can do themselves. The moral of this story of our times is that those who need the services and those who provide them should be as close to one another as possible, when not the same. To meet this criterion, I cannot think of a better social institution than the family. More so against an Asian backdrop where family ties are strong and family norms are respected.

There are other ways a low-income family can promote its health. And I say so with a certain confidence derived from the UNICEF experience of working with communities in many countries. Here, I would commend to you a broad division of labour—between the medical profession and the drug industry on the one hand and the family and the community health worker on the other. When illness comes we shall depend on the former but we shall rely on the latter to see that illness rarely comes. We must distinguish between illness care and health care.

Let us look at the pillars on which the edifice of health rests. An obvious one is food—its availability and one's knowledge of what is good for one's constitution, in terms of type, quantity,

preparation, and timing of the food.

In this connection, we must all rededicate ourselves to improved infant feeding practices beginning with prolonged breast feeding and proper food supplementation. This not only nourishes the child but protects it. Your organizations can take a significant place in the effort to reduce the decline in breast-feeding and to support better infant feeding practices. A cluster of deficiency diseases can be avoided by correct eating habits. The aggravation of these and other diseases can be limited the same way. Education for nutrition becomes even more relevant when it comes to the child, through the stages of maternal nutrition before and during pregnancy, breast-feeding, food supplementation and onward to the regular family diet. Whatever the consumption level of the family, it is important to prevent any depletion of the available nutrition, through worms or infection, social custom, habitual neglect or sheer ignorance. It has been demonstrated, in many parts of the world, that even literacy is not a prerequisite for acquiring nutritional wisdom and strength.

Another support for health is proper child-bearing and child-rearing practices. I mentioned breast-feeding which needs more protection than promotion—protection from unequally competitive commerce. A mother can easily be given the right information on the precautions she must take before, during and after birth and through the years of early childhood. Such knowledge is best imparted by someone emotionally close to her, in the family or neighbourhood.

Safe water, proper sanitation and clean environment are yet another group of inputs for health. What needs to be done here has been said by one of India's leaders, way back in 1935, in terms that carry more conviction than I can hope to provide. He wrote: "We are said to be a nation of daily bathers. That we are, to be sure, but we are none the better for it. For we bathe with unclean water, we foul our tanks and rivers with filth and use that water, for drinking and bath." Obviously, one does not have to be a doctor or degree-holder to learn the elementary principles of sanitation and hygiene. Nor does one have to wait for piped water supply, sewerage systems and environment specialists to arrive. A family with the necessary awareness may be expected to act

autonomously and to achieve the minimum essential level of health-giving cleanliness.

There is another set of steps a family can take, to prevent slipping into illness. This category of action would need a measure of external help in the case of poor families. Like giving iron and folic acid to expectant mothers ; immunizing children ; chlorination of wells; spraying of insecticides ; and administering simple remedies for minor, essentially self-limiting, ailments like coughs and colds, stomach upsets and small injuries. With some assistance from a trained health worker, preferably a volunteer from the community, any family can take over this function, which in some societies has come to be called "self-care."

There is thus scope for a range of actions a family can take to safeguard its health, even in conditions of serious economic inequality and social discrimination. As I have tried to illustrate, these actions are mainly promotive and preventive but to an extent even the curative function can be fulfilled, given the right kind of information.

I would like to add that there is no rift between the concept of a self-reliant family and a self-reliant community. The community is a one-step extension of the basic social unit that is the family. And nowhere is this natural extension more visible and real than in poor communities.

Equally, there need be no contradiction between self-care in health and on-going attempts to transform structures of social injustice. Indeed the care and the struggle reinforce each other. The poor can act here and now and if we let them succeed, another public health revolution will have happened.

Whether they will succeed depends on their becoming aware of the diverse causes of poor health. Their economic condition is one. Their lack of information, and knowledge of its usefulness, is another. It is the perception of UNICEF that both these causes have to be tackled together. For instance, we believe, and we assist in translating that belief into practice, that the productivity of the poor must increase. Income-generation by women is an example of one such aim we constantly pursue. Backyard

vegetable gardens to augment family consumption is again a simple idea we ardently support, and which has helped, in some countries, to alter dramatically the nutritional status of children.

The point needs to be made, and made emphatically, that health does not flow from gross national product or from higher expenses on the medicalised and centralised health care systems existing in most countries.

The way to health lies mostly through social awareness and human solidarity. Both these values should begin, like true charity, at home and in the family. Social security, even when it comes to Asia, is no substitute—but only a support and complement—for the security that the family gives.

I wish your deliberations full success and I look forward to the lessons you will be drawing from this seminar. Since it is the learning process that tips failure into success, may I conclude with a quotation from Mahatma Gandhi, who said : "If you educate a man, you educate an individual. If you educate a woman, you educate the whole family."

Reprint of the statement by Mr David P Haxton at the Asian Seminar on Total Health for the Family at Bangalore, 9-13 December 1981

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INTERNATIONAL TRANSFER OF RESOURCES AND NATIONAL DEVELOPMENT

David P Haxton
UNICEF Regional Director
for South Central Asia

There should be a greater transfer of resources within the national economy, a greater sharing of domestic resources. If this is not achieved, fairly quickly, more 'development' may mean more inequality and injustice. Foreign resources, even without strings attached, flowing into structures of injustice cannot bring about social justice.

Over the past several days, you would have discussed the many meanings of development, and what it takes for a people to develop. We in UNICEF have a particular perception of both the aims and means of this social process. Our understanding is born mainly of our experience in working, during the past 36 years and in many regions of the world, for communities caught in surprises like war or natural calamity or trapped, by the turn of historical events, in endemic poverty and its varied consequences. There is a certain convergence of our approach and the views of several thinkers in societies past and present. The philosophy behind it can perhaps be expressed simply as *'first things first'*.

UNICEF brings to bear on its task of catalysing social change, a modest measure of economic resources intended mainly to prime the kind of development process we ardently advocate. I take it that this is the reason why the Indian Institute of Public

Administration thought of a particular theme and a particular person for the valedictory address in this course on Development Administration. In addressing myself to the topic—International Transfer of Resources and National Development—I shall avoid getting involved in the currently competing theories of economics or sociology, but raise, and attempt to answer, the fundamental questions : development of *what, for whom* and *how.*

My first premise is that the primary aim of development should be to create the best possible world for children. Quite apart from the reason that this is what children deserve, the process of development takes time, effort and investment. Which is why I would say, without any touch of rhetoric, that development is for the future, and that children are the future.

We are an 'adult society' and it may take a little effort to gear our thinking to this elementary truth. Perhaps it will be easier understood if I say, in the accustomed language of economics, that it is a good investment policy to build up 'human capital', that it is bad economics to permit a malnourished, unhealthy, illiterate and growing population to act as a constraint on productivity and production. If we recognise this—maybe against conventional economic wisdom—we find a socio-ethical principle acquiring economic respectability as well. This is the perspective in which an international organization like UNICEF has been trying, sometimes quite successfully, to make humanitarian and development concerns converge to higher purpose. The poor majority in developing countries—and I may add the poor minority in developed countries—has to be enabled, on priority and through direct social measures, to overcome their poverty. Since labour is as important as capital, even in purely economic terms, this approach makes economic sense as well as it promotes social justice. And it is only logical that in developing the human potential of a country, the first priority should be the children and the youth.

Let us see what development of the human potential implies. It calls for the creation of conditions in which the physical, mental and social well-being of all the people in the country is possible. For this to happen, appropriate economics is an intellectual input, leading to the allocation of physical and financial resources for

human development, but it must be complemented not only by technology but also by social values or principles. There is, there need be, no conflict within this variety of economic, technological and social resources. The challenge of development is to derive the benefit of their mutually reinforcing interaction. But this alchemy can come about, only if those of us who are presently in positions of influence in society, are convinced that it can come about, and also let it happen.

I shall try to illustrate—rather than theorize on—some of the essential principles that ought to govern social relationship and how they work to the common good of all. Human development, through socially provided services like education and training, health and nutrition, sanitation and unpolluted water, employment and fertility regulation directly alleviates poverty but, in addition, increases the incomes of the poor and the gross national product. The national advantages of redistributing land, in order to invest in the smaller farmers and the poorer households, have been gathered by many developing societies, where the peasant has gained effective access to credit, markets, technology and health. In general, the larger the farm, the less intensively it is cultivated, the less labour it uses, and the less per acre it produces. This is an example with wider validity.

One can similarly show how greater attention to the allocation of assets, services and opportunities for the poorer households can increase the efficiency with which resources are used. It can help to meet needs now. It can help to increase productivity. It can help to ensure that the benefits of that increased productivity accrue to the majority. It can assist development in the future as well as in the present.

We in UNICEF have a name for this down-to-earth approach to development. We call it the *'basic services strategy'* or the *'basic needs first'* approach. I shall not go into it this morning—except to state some of its implications :

— it means non-imposition of ideas or schemes from outside on a community.

— it means decentralised organization of social services

and economic activity.

— it means training and assistance to local workers to assist the community to meet its own socio-economic needs.

— it means the use of technology, uptodate technology if necessary, not for its own sake, but to answer people's perceived needs, with priority to their basic needs.

— it means strengthening the basic social unit of the family and extending this principle of human solidarity to the local and national communities and beyond.

— it means more health workers and health centres; more nutrition workers and nutrition programmes; more teachers and primary schools; more water supply sources; more sanitary latrines; more income-generating activities especially for women.

— it means, above all, helping the mother to help the child.

We thus see that an attitudinal change to the means and the purpose of national development is called for. We are talking of a change in political priorities and style of functioning. We are thinking of a different pattern of social organization. Money is important but alone it cannot bring about change. Technology is necessary but it does not ensure the right direction of change. We need, more importantly, a more stable pattern of social relationship.

If I have not touched so far one part of the topic given to me —namely the international transfer of resources—it is because such transfer, however desirable for global good, does not make a decisive difference for national development. I say so, despite the fact that UNICEF activities are supported entirely by voluntary transfer of resources from richer communities and governments for serving low-income societies. But, in keeping with the orientation of our work, the accent is not on the transfer of physical or financial resources from the rich to the poor for the benefit of the

young, but rather on their strategic use to enable the poor majority in developing countries to come into their own.

UNICEF is constantly trying to increase the volume of such transferred resources in order to enhance the impact of its activities—again, not in terms of financial targets of money spent, or even in terms of physical targets of health centres or schools or sanitary latrines built, but in terms of human indicators of development, like the number of infants surviving the threat of death, the ability of schools to retain the children enrolled by poor parents, the capacity of the poor to prevent disease and disability, the level of human well-being, the quality of life.

UNICEF recognises the deteriorating global economic environment, the disruption of post World War II trend of more or less steady economic growth. It is already clear that the target of seven per cent average rise in gross domestic product for developing nations—set for the third UN Development Decade—is unlikely to be met. Even the social goals set by the International Development Strategy for the 1980's—a strategy which for the first time integrates social and economic aims towards human development —are in danger of receding. To make matters gloomier, the share of the rich world's resources that used to be transferred as outright grants or soft loans has begun to decline. The foreign exchange resources of low-income countries are getting fast used up, their trade gap is widening and monetary expansion is likely to fuel inflation in the absence of commensurate rise in production.

In such a context, it is of course important to work for an equitable international order. An increase of some 12 to 20 billion dollars a year in the concessional resource transfers from the rich countries particularly to the low-income countries would be a minute percentage of the world's six trillion dollar gross global product but it would provide the critically needed foreign exchange for a successful worldwide effort for the social goals set for the 1980's and beyond. Again, greater access on equitable terms for the manufactured products of the developing countries to the markets of the developed countries would assist the former in their attempt to develop. And the developed countries need to be persuaded that their prosperity cannot co-exist with other

peoples' poverty.

So, larger international transfer of resources is both necessary and urgent, and must be worked for with perseverance. But I submit the developing countries should not lose their sense of proportion. In quantitative terms, domestic development is funded by foreign resources to not more than a small percentage, in most cases. Even in functional terms, it is dangerous to allow foreign dependence to decide the pace and direction of development. Much of what I said in the earlier part of this address goes to show that self-reliant development is possible and desirable. Indeed what is important is not how much foreign resources one earns but how, and to what purpose, they are used. They should be used as a lever to limit the need for future dependence ; and one makes a distinction here between vertical dependence and cooperation in terms of equality.

It follows then that there should be a greater transfer of resources *within* the national economy, a greater sharing—if you like —of domestic resources. If this is not achieved, fairly quickly, more 'development' may mean more inequality and injustice. Foreign resources, even without strings attached, flowing into structures of injustice cannot bring about social justice. National development is therefore predicated more on a just dispensation and proper application of domestic resources for human development, than on transfer of foreign resources.

To come back to the purpose and priorities of national development, let me answer the basic questions we raised earlier— development of what, for whom and how—through some specific examples. If a country has to choose, for whatever reason, between a set of alternatives, it would be well-advised to invest on priority :

— more on basic learning for all, than on higher education for a few.

— more on primary health care for all, than on sophisticated hospitals for some.

— more on production of nutritious food at prices all can

afford, than on crops that bring profit for a few.

— more on prevention of disease and disability, than on cure or rehabilitation.

— more on public standpipes for water supply than on individual house connections.

— more on simple sanitary latrines than on expensive sewerage systems.

— more on efficient public transport, than on private vehicles.

There is documented evidence that this order of preference makes economic sense, in terms of return on investment over a period of time. Indeed, what is uneconomical is the unrealistically high, and largely imitative, standards set by 'experts' and the high costs and small coverage that inevitably result.

Again, there is no implication in this approach that second-rate technological options have to be accepted. Rather, the best that science can offer has to be applied in a social design that benefits all people.

The merit of the 'basic needs first' approach is that its application need not wait till justice arrives in social relations. In fact it paves the way for social equity. It is for professional people, opinion leaders and the public media to become convinced of the relevance of this development strategy and to influence the decision-making apparatus in its favour. And if we agree that children are the focus of development, tomorrow, for them, will be too late.

Reprint of the address by Mr David P Haxton at the Course on 'Development Administration', Indian Institute of Public Administration, New Delhi on 19 December 1981

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PROGRESS REPORT
1981

of the UNICEF Regional Director
for South Central Asia

Looking back on 1981 in South Central Asia, presently the most extensive area of UNICEF regular operations, the old question cannot be avoided : Can more 'development', such as it is, mean less poverty ?

The answer will not be "yes", unless a massive, direct assault can be mounted at the roots of the existing social condition in a strategy of development, different from those currently applied. Governments know this as well as UNICEF. Some are trying in earnest for a change in the direction of development. All are committed to such change to some degree. But the majority of the region's 750 million people has completed another year waiting for that decisive thrust. The order of casualties, meanwhile, in terms of the number of children who could not grow, or survive, is too well-known to need recounting here. Roughly, the region is heir to a fourth of the world's child-related adversity. It must be asked : how can governments, with or without external assistance from UNICEF or other agencies, stem this tide ? Can the struggle be won without people's active involvement, on as massive a scale as the size of the target of attack ?

The prevailing pattern

In a region as varied as South Asia, it is risky to generalise. Yet there is an overall pattern in the prevailing poverty. The variation in its intensity and spread seems to be a matter only of degree. In Sri Lanka, (that oft-cited example of social development at low incomes), a quarter of the families live at or below the poverty level. In India, taken as a whole, the proportion would be around half ; in Nepal and Bhutan even higher. Sri Lanka seems hard pressed to maintain its level of investment in children, in its anxiety to provide work and wages to those of them that have grown up in the scheme of welfare. This problem of competing demands for economic growth and social development does not arise with similar sharpness in countries where both demands have not yet been expressed.

Population

Populations continue to rise at rates that offer little comfort. The annual average rate for the region hovers around two per cent. While death rates have fallen more by control of epidemics than through positive gain in physical well-being, the birth rates have not been reduced to a level that permits the mutual reinforcement of population growth and poverty to be broken. The crude birth rate per thousand people varies from 28 in Sri Lanka to 47 in Afghanistan, India's tally being 34. Governments are aware that there are no shortcuts to population control : that abject poverty, in its harsh profile, is the unsolved problem.

Migration

There is another manifestation of the population growth that impinges on development prospects for children, and that is the inexorable migration to cities and towns by large, poor families in search of a living, that is not always found. It is true of all the South Asian countries that the urban population grows at a rate faster than the exponential growth of the national population. Calcutta is an example of the consequences. Kabul is another. There are numerous others. It appears unlikely that the tide of migration to urban centres will be stemmed. UNICEF policies and approaches will need to be applied more to this problem.

Politics

There is no dearth of expressed goodwill for anti-poverty programmes. Indeed such programmes are part of the planning routine of all the countries. And thanks mainly to the continuing advocacy efforts of UNICEF staff and, in no small part to the awareness generated by the International Year of the Child, the problems of national planning for health and learning, nutrition and environment are, at last, beginning to be looked at on behalf of children ! But even in societies where the concern for children is relatively pronounced and productive, this trend is only beginning. In nearly every country, the needs of all children are yet to be related in significant ways to the aims of national development, even when the planning process has acquired a measure of professional sophistication. This, it must be said, is not due to any lack of support at the political level of government for children in need. In fact the support is articulated, irrespective of whether the country concerned is under one-party rule or monarchy, a theocratic republic or constitutional democracy. However, the apparent lack of pulling power for politics to bring up socio-economic development to the level of aroused aspirations is there for all to see. Also, expressed government commitment does not always translate into bureaucratic commitment and action. It is not the purpose of this report to dissect the factors at play in the region but UNICEF cannot fail to take note that the political engines are not yet fully gearing to meet the needs of the poorest children.

Resources

If national policies have not as yet been as productive as they may have been from the poor family's point of view, there are a number of explanations. The readiest of them is the shortage of resources for development relevant to the poor. This, in turn, can be explained by some or all of the following factors :

— The recent trend toward spending for purposes other than development as against investment for development especially of and for people. This is not a uniform feature of all the countries in the region but the recent spurt has serious economic, development

and humanitarian implications. To the extent, this is dictated by the global questions, there are no purely national solutions.

— Inflation has for some years been eating into the purchasing power and consumption levels, especially of the poor. The fluctuations in the rate of inflation may reflect the success, or failure, of government policies designed to manage supply and demand, but the overall trend of price rise has the effect of making high-cost economies of low-income countries. This by itself is reason enough for alternative financial, technological and social strategies for development— (perhaps like the ones UNICEF has been advocating with limited success).

— The international transfer of resources into the region has shrunk, as evident from the reduced volume of concessional aid, a widening trade gap, the effective devaluation of currencies ; and various other consequences of recession in the developed part of the world.

— Apart from the financial stringency which has driven practically every country in the region to borrow in the hope of stabilising the economy, there are acute problems in regard to fuel as well as food.

— The capacity quickly to absorb additional resources in social service delivery presents a set of problems not yet solved.

Energy

The region produces the bulk of its own energy consumption— about 80 per cent in India's case, half of which is met by coal. The smaller countries have a reliable source in hydroelectricity. The import of oil is, in this sense, marginal, but the steep rise in petroleum prices over the past seven years has magnified the level of imports into a drain of export earnings. The answer is in sight, in India for example, in terms of tapping known reserves and reducing imports. There is progress in this in that about half the

current consumption is met by domestic output.

Food

World food production is estimated to have reached a record output in 1981. This is true of a large country like India, too; yet it has had to dip into its food reserves, over the past year or two, to such an extent, that it is back in the world market as a buyer of wheat. Which means that the record harvests during 1981 in India, and some other countries like Nepal, should be taken as evidence of the scope, as well as the need to step up domestic food production. Possibly, there is room for improving the management of distribution as well, if occasional reports of stocks lying unutilised are any indication. From a nutritional point of view what matters is that food production be increased (and food losses be reduced) in ways that benefit the poor—who grows it, what is grown, who gets it ?

Employment

Unemployment has been rising in the developed world through 1981. In South Asia the expansion of formal employment opportunities is not keeping pace with the additions to the labour force—at around 10 million a year for the region. This means that the bulk of this number is absorbed partially into subsistence agriculture, household industry and 'informal sector' services, and partly into the ranks of the unemployed. The number registered at employment exchange (16 million in India in November 1980) is hardly an index of the total number of the unemployed, let alone those underemployed.

A comparison

In outlining a regional picture of 1981 to provide the backdrop to UNICEF experience over the year, no attempt has been made to describe each country in terms of those development indicators with which UNICEF is directly concerned. Each country report provides that description. But it may be stated, in an overview, that events or trends during 1981 do not presage any significant shift in the development rating, in social or economic terms, of the seven countries of the region. Six of them remain trapped in

the low-income category and three are designated to be among the least developed. It may be noted, as a comparison, that even between these six, national indicators vary in infant mortality from 37 per 1000 live births in Sri Lanka to 184 in Afghanistan; in female literacy from about 71 per cent in Sri Lanka and the Maldives to four or less in Nepal and Afghanistan; in life expectancy at birth from 69 for Sri Lankans to 41 for Afghans; in per capita gross national product from US $230 in Sri Lanka to $80 in Bhutan.

These differences are, as noted earlier, not so much of type as of degree. They reflect stages of social evolution and development, not necessarily measured in time. Some of the countries are in their fourth development decade, some in their second.

Experience of action

The year could not have started on a better augury than the adoption, by the General Assembly, of the International Development Strategy setting targets of precisely those social goals that UNICEF has been advocating. As governments in the region were parties to this decision, a widening and deeping of UNICEF cooperation with them was mutually agreed as feasible as well as necessary.

In negotiating country programmes for the initial years of the Third International Development Decade, there was the added advantage that in areas like health. drinking water supply and sanitation, global policies, targets and approaches had been settled and it remained only to translate them into practical programmes at the national and sub national levels. Programmes and ambitions like universal elementary education, nutrition supplementation and nutrition education were part, more or less, of on-going national plans. Given the funds for stepped-up assistance, it was not difficult to get projects developed and to make commitments in their support.

This process was helped by the post-IYC awareness of planners and decision-makers of the need to reflect, in the development plans and in positive terms, the concern for children. This did not mean that the facts about the condition of children,

or the means to change it, were all at hand, but a new interest is visibly there. Similarly IYDP opened eyes to at least two things: the near-total absence of reliable data on the extent and causes of disability; and the critical relevance of preventive action, especially in low-income societies.

Reviewing the experience of working with governments through a year that started on a promising note, two sets of comments come to mind: one on some of the major themes of cooperation and the other of a more general nature.

Area Development

The resurgence of this concept in a practical shape was possible because of a happy coincidence. While governments were concerned about glaring sub-national disparities, UNICEF was interested in converging on precisely the deprived areas social inputs and economic development, in addition to the approach of serving the same children and women with the same basic services at the same time. Popular involvement in design, appraisal, implementation and evaluation is an essential feature of this approach. The idea has caught on, consequent on the success of initial experiments and a number of districts in India and the other countries are coming to consider this approach. The country programme for Nepal has a strong emphasis on this convergent approach. UNICEF commitments in this regard are substantial and the pattern now being set is likely to continue in the foreseeable future. The area development approach also lends itself for adaption to the given environment—rural, tribal or urban.

From the kind of problems so far encountered, it appears that the main determinants of the long-term success of this approach may be:

— the willingness of governments to devolve responsibility as well as power to the sub-national authority designated by it for the project, under a suitable system of accountability.

— the development of flexible, non-bureacratic institutional infrastructure for viable community participation. Ways also need to be found to blend sectorally

structured channels.

— active association of voluntary organizations with the process.

— speedy response mechanisms in government (and UNICEF) to projected needs and changing situations.

Primary Health Care

All governments are committed to the approach. But the definition of primary health care seems to vary from country to country ; and between governments and the medical professions. The distinction between health care and illness care tends to get blurred. The role of the community health worker, who is to assist families to take care of their own work, vis-a-vis that of the doctor, is again interpreted differently. In the resulting confusion, primary health care is emerging in some places as an extension of the established health services, rather than as a means to make conventional health services more efficient. Another reason for the lack of definition is the higher weightage continued to be attached to curative functions with the tendency to neglect the preventive and promotive aspects.

The slow progress of the Expanded Programmes of Immunization is a case in point. For the year there is little to show, in terms of diseases curbed. It is to be hoped that this is a short term problem which during 1982 will see changes introduced which include : improved production capacity ; improved management and logistical support including another look at the presently rather stylized cold chain systems ; more involvement or non-medical personnel ; innovative delivery systems ; and more public promotion of prevention and participation.

A way needs to be found for shifting UNICEF assistance from linear extension of health centre systems alone to *organization* and *management* of primary health care. This should be possible as more and more WHO and UNICEF speak with one voice at the country level.

The one country in the region where primary health care is

getting off to a non-controversial start is Nepal. The reason may be four-fold : the conventional medical services are not as developed there ; health planning is decentralised to the district level ; a health information system is being developed in support of health promotion ; and there is good understanding between government, WHO and, UNICEF, as well between them and other development agencies.

Infant Feeding Practices

UNICEF has, over the years, assisted in this region extensive nutrition supplementation programmes for children and nutrition education for mothers. This has been successful in part depending mainly upon the commitment and efficiency of those who ran the schemes. There is also ample scope for conceptual and operational improvements in these schemes which UNICEF is currently exploring with the Indian government.

Another opportunity for UNICEF to come in a big way to the aid of poor infants and young children, presented itself when the World Health Assembly adopted the International Marketing Code for Breast-milk Substitutes. The climate in the region is conducive to massive public information efforts. The baby food industry is not so entrenched as to offer an impossible obstacle. India is proposing fairly stringent legislation. Having banned advertisements of substitutes for mother's milk, another country may ban their import.

But, as noted, the battle has to be won by the force of argument and persuasion of the public and professional groups—in order to protect the traditional practice, to introduce proper and locally available weaning foods, to spare a thought for nourishment during pregnancy.

As is usual in open societies, the focus of public good is blurred by interested controversies. UNICEF has moved ahead with publication of a series of select readings, is approaching paediatricians and nutritionists through mass mailings, and working to quicken the pace of government action, in full collaboration with WHO. This is among the more hopeful lines of current action.

'Vater Supply

UNICEF spends about a quarter of its programme budget in the region on drinking water supply. The pace of cooperation is maintained, for governments have been alerted, and alarmed, by the situation that led to the IDWSS decade. Indeed water supply is the entry point for the basic services strategy in Nepal and Bhutan.

There are many positive points that can be made, but what is more important to state here are the drags on the desired effect, which UNICEF is trying to overcome :

— the lack of awareness of the affected people of the primary need for safe water. They are used to unsafe water and its consequences.

— the voice of the local people, about the location, style, setting up and maintenance of the facility is not (yet) fully sought.

— neglect of maintenance and laxity in management.

— overdependence by the people on government; short-sighted criteria hamstringing social policy; and, finally the perennial paucity of resources sometimes made worse by imitative construction styles and standards.

The focus of UNICEF falls increasingly on these critical long-term aspects of the water supply policy.

Sanitation

Sanitation is the weakest link in the UNICEF chain of basic services. It is the lowest priority for governments. It is non existent in the vast rural areas where most people live. It is only slightly different in the urban centres, barring upper class neighbourhoods. We had hoped to begin anew on these issues but financial/budget constraints have slowed us down. However, as massive as the problem is, there is some — admittedly modest — sign that there are approaches which work—or can be made to work better.

Bhutan has produced a plan for rural sanitation improvement through the district leaders. In India, while investment priority could be higher we believe, significant investments in urban systems continues. The area development schemes, rural development activities, ICDS and the water programme are stressing elements of good sanitation. Especially worth watching is the innovative venture in some UNICEF supported urban development projects of public latrines supported by fees paid by the users !

Environment

In a region where ancient religion sanctified man's ties with nature, there is a steady deterioration of the life-sustaining quality of the environment. Unplanned spread of towns, felling of forests, erosion of mountain slopes, pollution of air and water— these are increasingly evident. The growth of industry, pressure of population, commercial rapacity and helplessness of authority are among the apparent causes. The trend is visible in all the South Asian countries and nearly all parts within countries. There are government policies in favour of preserving the ecological balance but so far they have not been winning the battle.

This is a case where cure is impossible and prevention is the only option. The present situation has direct adverse implications for tomorrow's world.

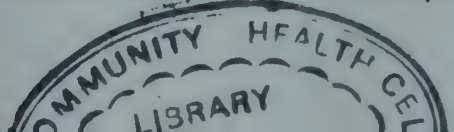
A Way Ahead

But what about our first two questions ?

It is believed that governments can address the major problems of children in significant ways given a few simply expressed elements : recognition that economic decisions (as vital as they are) have social consequences. Equally, of course, social decisions have economic consequences. Bringing these into balance is the major challenge.

Political will to do the different and make a difference is a key element for children in development.

A readjustment of priorities especially related to the applica-



tion of revenue combined with a reordering of the ways in which resources are now applied is a key element for advocacy.

Increased transfer of resources will need also to include commitments to apply them to the problems of the majority in fields of primary health care, basic nutrition for people, primary learning and the other related basic services.

UNICEF will be arguing these cases in all countries over the next few years and, fortunately, there are two indicators that augur well for these discussions; the first is that the governments are increasingly interested in looking at the problems of children in different ways; second is that development agencies are also more receptive to the argument of the importance of planning for children.

Coupled with this is the continuing approach to combine two additional resources. The first of these resources is the collected *experience* of practical measures of low cost which work. The second of these resources is *people*. The combination of people undertaking activities for their own improvement and that of their communities with these collected experiences is a development approach which UNICEF is pursuing. Among some things which will be more widely promoted and encouraged are :

— *improved infant feeding practices* including maternal nutrition, breast feeding, public education on infant feeding, suggestions to change hospital practices, improved support for proper weaning, and cooperation with public media in these endeavours.

— *improved management of infant diarrhoea* including a combined approach of encouragement to the increase in production and distribution of oral rehydration salts and promotion of home remedies based on products available to the mother every day and in the home where diarrhoea strikes first.

— *improved cooperation with public media* in all of the above and in approaches to improved sanitation. In this connection agreements have been reached with organiza-

tions in two countries and the third is under way.

— *improved promotion of the basic services* approach with special emphasis on the synergistic positive effect which convergent services have when applied to the same children in the same place at the same time. This is evidenced by the increasing support to the ICDS activities in India.

— among these basic services *primary health care* as an approach offers additional opportunities if we can concentrate on preventive questions, community based health care and not on linear extension of medical facilities.

— *increased cooperation with non-governmental organizations* especially of those who already are implementing the basic services approach and usually only need some support for the extension of it.

— *improved promotion of the understanding that education is more than an accumulation of factual information leading to qualifications for something (and thus presumably an escape from poverty).* We will attempt to pursue the conceptual understanding that learning associated with health, environment and improvement of the quality of life constitute an education which is relevant and productive.

The foregoing are only illustrative. The work plans for UNICEF in the region will still need to include a persistent effort to alter opinions about UNICEF so that UNICEF is less and less looked to as the supply arm of development ministries and more as the lead agency for children.

In this connection progress is being made but it is slow.

New Delhi, 15 December, 1981

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PROGRAMME TRENDS IN SOUTH CENTRAL ASIA

Statement by David P Haxton, Regional Director UNICEF South Central Asia, to the Programme Committee of the UNICEF Executive Board, May 1982

Reporting this time last year on the general prospect for the 275 million children of South Central Asia, I expressed the cautious optimism that the positive factors would outweigh the negative ones—in a likely movement of human development through the 1980's. A marginal strengthening of the adverse trends since then does not reverse this prognosis—given understanding, patience and a steady application of an appropriate mix of resources, within a well-defined strategy. The global, historical experience of UNICEF has yielded the basic elements of a strategy. It is our aim and effort to relate them, country by country, to the changing realities.

Maldives

I would like briefly to present the rather compact case of the Republic of **Maldives**. The Executive Director has commended for your approval a programme of cooperation for the next five years, the greater part of which is to be financed from noted funds.

Among the smallest of UNICEF partners, the Republic of Maldives is, like Bhutan, Nepal or Afghanistan, one of the 30 least developed countries. It falls below the average for even these countries in economic and health indicators, though the rate of literacy at over 70 per cent, is a very hopeful factor. The chances are real, if not easy, of all the 200,000 people including 60,000 children spread over 200 islands, attaining an acceptable minimum quality of life by the turn of this century. The problems and their causes are known. The solutions are also within reach, provided some of the lessons learned there and elsewhere are remembered and applied. This is, I believe, where UNICEF comes in, to advocate and support resolution of problems of acute consequence to children, resolution at source and on local initiative.

I would like to stress a few points of interest in this proposal.

First : You will note that the programme is a blend of general resources and noted funds which comprise one whole.

Second : UNICEF general resources will be applied to the major problems uncovered by the situation analysis of children.

Third : Additional funds for the noted components will be applied to the supportive developments.

Fourth : A thread that runs through the 1982-87 programme is the progressive devolution of effective, practical power to the islands without detracting from the central responsibility of the government in Male. There is no other way to move towards full coverage of each island community by child-related services like nutrition, water supply, sanitation, health and education. An attempt is also being made to recognize and resist the obvious risk of these aims being downgraded by a largely imitative overemphasis on economic goals often devoid of human content.

Bhutan

I am glad to note, in this context, a significant trend today in **Bhutan** also, towards decentralised development planning and administration. Instead of the national plan being discussed and

finalised at Thimphu on the basis of government's perception of people's needs, each of the 18 districts participates in formulating its plans in consultation with its own people. It does not become easier but it does become more meaningful for UNICEF to work for children, in a design where local plans bring forth the national plan, rather than the other way round.

This is not to imply that the basic problems of malnutrition, ill-health and illiteracy are nearing solution in Bhutan. The Board approved a programme of cooperation last year for Bhutan. This included noted portions and we would be grateful for further discussions with funding sources to meet these needs.

Nepal

My colleague, the UNICEF Representative in Kathmandu, will introduce the Country Programme for **Nepal**, 1982-86.

The often tenuous rapport between the people for whom the services are intended, on the one hand, and the government and development agencies including UNICEF, on the other is a common constraint. The community is at times not even aware of the benefits thought up for them by planners at the national level with or without international support. This is particularly true of social development projects which generally have low visibility and long gestation. Were the community aware of plans that affect their lives, their involvement in shaping and effecting them would be more, and this cou d quicken the pace of decision and action. In this perspective, there is, I find, a common denominator to the three major themes before this Session :

—Cooperation at Intermediate and Local Levels ;

—Maintenance of Community Water Supply and Environmental Sanitation Facilities; and

—Reaching Children and Women of the Urban Poor.

So, I would like, for a moment, to look at them together and in relation to our activities in South Asia.

Cooperation at Many Levels

Within defined parameters governments are increasingly willing to let UNICEF deal with the intermediate administrative layers between the national and local levels. This slow trend away from tradition stems from realising that the existing gaps in services, as well as of knowledge, cannot be filled in only from the national capital.....or, at least in the near future.

It is also being recognized that there is no way except to tap the human and other resources at the local level, including non-government agencies, most of whom work among the people at that level.

UNICEF has been advocating, for some years now, an inter-sectoral, inter-disciplinary approach to development for children. We also are trying to encourage a functional integration by assisting in bringing together the policy-making, financial, managerial, technological and participative dimensions of development. This implies a corresponding change in the understanding of UNICEF staff of their primary role, and in the organizational structure and style of functioning. We understand this as going beyond decentralisation, towards attitudinal change and we intend to carry it forward as soon and as well as we can.

The process has been initiated and has gone some way in the South Central Asia Region. This is especially the case in India and Sri Lanka. **Sri Lanka**—for which a country programme of cooperation is well underway for presentation to the next Board Session—shows us another aspect of this approach. Last year the Government held a symposium on children. It was a retrospective look at the past 50 years; an analysis of the current situation; and a perspective for the next 50 years. A truly magnificent and significant event. The country programme of cooperation by UNICEF will, within the context of the national programme for children, concentrate on major problems which cut across traditional sectoral lines; and, these, principally are those affecting the young children. But—more about that next year.

In **India**, our major partner, the Ministry of Social Welfare has accelerated activities of coordination. There are quarterly meet-

ings in which each agency of government with whom we are working is represented. Plans are reviewed, constraints frankly discussed, changes proposed. Moreover, the Coordinating Committee is also looking into problems cross sectoral in nature like : improved infant feeding practices; goitre control and soon we hope, diarrhoea management. The Prime Minister recently announced a 20 point programme, with appropriate and significant budget support. Of the 20, 11 are matters of concern directly or indirectly to children and I am pleased to report we are closely linked with the Government of India in supporting implementation.

Also, it should be repeated that the major objective of the government in the plan of cooperation with UNICEF is **convergence** : the convergence of basic services for the same children in the same place. This is manifested by increased emphasis on area specific planning; urban and rural development schemes; and the doubling of inputs in the Integrated Child Development Services.

Water, Sanitation

The process of marrying the power of the state with the potential of the people is, once again, of direct relevance to the goals and progress of drinking water supply and environmental sanitation. There are limits to what governments can deliver especially in the rural expanse; and equally there are limits to what materially poor people in their families and villages can do. Together, substantial results have been demonstrated. If in India, at one time, over 80 percent of handpumps were in a state of disrepair, the core reason was the use by the community of a pump designed primarily for family use. This design has been improved and will be further refined and adapted. Also, the community has been involved in the first step of maintenance, beyond which the state machinery steps in from the block level and, if called for, from the district level. We are keenly pursuing, wherever possible, systems that need next to no maintenance, like gravity-flow schemes in Nepal, Bhutan and India. Equipment maintenance and improved logistics management are constant goals—even though these ideas meet resistance among some gevernment staff. But above all, we are trying to foster, as committed but impartial partners, a culture of mutual trust and responsibility between the people and the layers of officialdom.

A much-needed innovation in the long-neglected area of sanitation is the 'pay-latrines' and wash-rooms coming up in some of the congested slums of India. UNICEF is doing its bit and is anxious to clone this experiment. State Governments in India have become very interested in the approach. The Coordinating Committee—to which I referred earlier—is also seeking ways to extend the idea to the ICDS blocks. This idea is succeeding, in our view, also because more and more citizens—though not enough of them—are assuming a social responsibility. The government-managed urban sewerage and water supply systems have been linked to the scheme.

But beyond the city limits remains a largely untouched problem, in every country of the Region. Sanitation is today the concern of a few. We hope to add a post or two to the Regional Office to address this problem. We will not achieve a goal until everyone is concerned enough to work for it. Here UNICEF has a role of public education awaiting it.

The Urban Poor

As you will have seen from the case studies, there are some remarkable examples of urban community development in Indian slums. UNICEF is actively associated in their progress. The stage has been reached when nearly every major town in the country is keen on starting a project of this kind. What is perhaps the most interesting and instructive aspect of the experience is the merging of many levels. Indeed, depending on capacity and readiness, we have banks and town planning agencies, health organizations and educational bodies, cooperatives, women's clubs and social research institutes, Rotarians, Lions and Jaycees, finding fulfilment in working together to transform city slums into livable places. We encourage this joining of forces.

I need not go over the lessons learned because these are well-documented but I would make the point that the more the community is encouraged to think, plan, initiate, support, manage and monitor social development services, the greater will be their impact, the longer their sustainability. The bleaker the finances the more relevant the community approach.

UNICEF has an eye for things that work. Equally we need to discover and disseminate what make things work.

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UNICEF POLICY ON CO-OPERATION IN EDUCATION

Statement by Alexander C. Tosh, Principal Officer, UNICEF, South Central Asia Region, at a Conference of State Education Secretaries in New Delhi on 17 February 1982

At the annual meeting of the UNICEF Executive Board, in June 1980, a report was tabled by the Executive Director which had been prepared on the basis of a global survey and assessment of UNICEF assistance to education in the previous seven years. The report covered five main areas :

(i) a review of UNICEF policies of co-operation in education;

(ii) an assessment of viability and appropriateness of those policies in the circumstances of the present day;

(iii) a statistical review of UNICEF'S financial inputs to education;

(iv) a qualitative assessment of the applications of UNICEF policies in programmes and projects;

(v) recommendations for future application of policies.

The policies reviewed in the report had been adopted by the Executive Board in 1972 on the joint recommendation of the UNICEF Executive Director and the Director General of UNESCO. They had been reconsidered in 1973 and 1974 to ensure their capacity to accommodate a stronger emphasis on non-formal education. In 1979 the Executive Board again critically examined the policies. In 1980 it was reaffirmed that the general policies "still remain pertinent and permit UNICEF to respond to a broad range of needs."

The statistical review of UNICEF's financial inputs to education revealed that in 1979, 13 per cent of total programme expenditure went to primary education (an increase of 25 per cent over the 1975 figure) and 3.5 per cent to non-formal education (doubled since 1975). It revealed also that according to UNESCO projections, enrolment in primary schools in developing countries would need to increase by 400 million in the next 25 years, even though enrolment had doubled between 1960 and 1975 to a total of 246 million. This is the daunting problem which confronts educational planners.

The qualitative assessment revealed the following :

— that large-scale reforms designed to bring effective learning experiences within reach of all children had so far been attempted in only a few countries;

— in most countries UNICEF co-operation has reluctantly assisted a process of incremental improvement (as distinct from radical reform) largely through support for training but also in helping build national capacity to produce teaching aids, especially text-books;

— not much progress had been made in the introduction into school curricula of education about water use, food and nutrition, health and child rearing etc.;

— there is a growing interest in countries in pre-school education, and some interesting beginnings had been made with community-based models, for which there is a large field for extension;

— while popular involvement is wide-spread in non-formal education, it is rare in the local management of primary school systems; such involvement is probably the key to the extension of primary schooling.

It was the Executive Director's view that these revelations have clearly brought forth the need for one main general emphasis for the future, namely *to encourage and support the convergence of schooling and of non-formal education in the various fields in which UNICEF co-operates ((e.g. women's activities, water supply and sanitation, food and nutrition, helth etc.)* This conclusion is effectively a firm endorsement of the UNICEF conception of education as having social rather than pedagogic parameters.

In the last section of the report, which dealt with specific recommendations, the Executive Director proposed that while the general policies on assistance to education are still valid, nevertheless they could be focused more sharply along the following lines :

1. Because of UNICEF's concern for the survival, care, protection and development of the child, UNICEF will support measures to strengthen a comprehensive educational approach, as a component of basic services for children.

2. UNICEF will give some support for the reorientation of schooling.

3. UNICEF will encourage and support more attention to out-of-school children, who often suffer from lack of an organizational base for services benefiting them.

4. Literacy should receive more attention and will be supported in a more focused way to increase its effectiveness.

5. UNICEF will support the exploration of new solutions for the care and development of the young child, including the adaptation of traditional practices.

6. UNICEF will give more attention and support to the development and application of models of community involvement

in formal and non-formal education, and exchange of information among countries.

7. UNICEF will continue to direct its inputs to services for underserved groups, especially girls and women, and low-income areas.

8. UNICEF will support the development of monitoring indicators and systems for use by national and local authorities.

9. UNICEF will be prepared to contribute to regional exchanges of views among ministers and officials and to the articulation of different models for the organization of broadly based services.

10. More systematic orientation will be given to UNICEF programme staff, and in future UNICEF will recruit more staff with professional qualifications in education.

11. UNICEF's policy of encouraging those educational activities that bear more directly on child survival and development requires, for its application, co-operation with other funding and technical agencies, such as : the World Bank and UNDP; bi-lateral non-governmental agencies; UNESCO; specialized agencies in other sectors where non-formal education is important.

The first of these proposals places education firmly under the *aegis* of basic services—one of a complex of amenities on which the survival, care, protection and development of the child depend.

It is believed that education can play a central and integrating role in the planning, installation, maintenance and beneficial utilization of other basic services in health, water supply, day care, income-generation, etc. In addition to conventional pedagogy, teachers and tutors are becoming increasingly involved in a wide variety of hitherto "non-pedagogical" activities. UNICEF will also look for ways of strengthening the educational input to all development programmes in basic services, and in future UNICEF will more actively seek opportunities for this. This refers specifically

to educational *content*. In the UNICEF view it must be selected and presented to meet these broad issues of child survival, care, protection and preparation for life. UNICEF allocates top priority to learnings which lead directly to improved, health, sanitation, nutrition, etc., not academic or theoretical learnings from books *about* such matters (these may come later and are a necessary preoccupation at higher levels) but through practice and *involvement* in the up-grading of the human condition. "Tinkering" with curricula or revision here and there of subject syllabi are unlikely to bring about comprehensive educational change nor will successive additions of new curriculum "elements," overloading what is already overburdened. Only wholesale curriculum reforms inspired by the national goals (which are, in fact, quite explicit on the subject) and by the fundamental needs of people in their many and varied environments will suffice.

The second proposal derives from the fact that educational content and the systems, or structures, of education are inseparable. If we conceive curriculum as the aggregate of learning situations into which learners are deliberately introduced, then consideration must be given to the means whereby these learning situations are selected, designed, contrived and provided. The most universal of these is the school system.

In the past, UNICEF co-operation has sometimes been extended to linear expansion of the school system and the related systems in teacher education, curriculum etc. *This can no longer be the UNICEF role.* (There are, in fact alternative sources of funding for this.) UNICEF will co-operate in the reorientation of schooling (a) to reorient curriculum content to issues which impinge upon the child's life and environment; (b) in qualitative improvement and reorientation of teachers for that purpose; (c) on practical work and involvement and, where appropriate, productive enterprises; and (d) on the use of the school to serve the community in all developmental endeavours.

The third proposal responds to the situation that the educational system has not yet reached all children. It may be some time before Governments will be in a position to provide universal primary school education. So, as always, the poorest will be the

last to be enrolled. Of all children, these are of the greatest concern to UNICEF and while UNICEF will continue to strongly advocate their absorption into a modified and universal school system, meanwhile ways will be sought to provide appropriate learning opportunities through alternative channels. Inevitably these will be on a comparatively small scale and sometimes inspired by individuals or voluntary organizations. Due to their proximity to people's needs and their intimate involvement with communities, they are often highly cost-effective and innovative. Much can be learnt from out-of-school provision of educational opportunity which is generally shorn of irrelevancies, at least partially self-supporting and an integral part of community life and development.

It will be seen from the above three proposals which have been examined in detail and the additional eight which are largely self-explanatory, that UNICEF's view of education is a broad one and encompasses activities of many kinds which beneficially affect survival, protection, care and preparation of the child. It accords to education a central place in all human endeavour. It implies also a more incisive analytical approach to identification of children's needs and an increased specialist capacity to relate those needs to educational policies and strategies.

While survival, protection and care of the child can be assured and supported by the availability of a complex of services in health, nutrition, water supply, sanitation, etc. those services in turn rest ultimately on a foundation of individual and societal understanding, enduring responsibility and finally beneficial utilization. The services which ensure survival and facilitate the nurture of the child—and the security, stability and cherishment which promote happy and healthy development—are as much (if not more) the product of human development as of material. Enlightened participation, heightened awareness and responsibility, relevant knowledge, understanding and skills essentially complement adequate physical amenities.

UNICEF assistance is therefore, while often of a material nature, a contribution to the comprehensive development of individuals, communities and societies. Material assistance has to be balanced

by advocacy and promotion of human development. By themselves, material inputs are not only unbalanced but inefficient, possibly even detrimental to the ultimate goal of human and social development. One function of education is to help internalize and organize physical reality in the minds of people.

Conclusion

On the main premises, therefore, that individuals' or society's ability to protect and care for the child depends as much as attitudes, values, knowledge and skills as it does on physical structures, it is concluded that education is an essential ingredient of any UNICEF assistance or endeavour in basic services. Education is not only a basic service itself but essential in some form to every other basic service which contributes to survival, protection and care.

Preparation of the child for its future includes not only the provision of those services which enhance the physical quality of life but also the edification of the young individual spiritually, morally, emotionally, scholastically, so that he will develop the capacity for his own survival and care, and for the sustained development and improvement in family, community and society. In this sense, education is a basic right. UNICEF has a duty to advocate fulfilment of that right. Inevitably therefore it is drawn into supporting development, reform, planning and implementation of ventures in educational content, systems, and/or methods. Perhaps the greatest impact UNICEF's co-operation can have is on operational research, experimentation, dissemination of ideas, planning and implementation of reforms, support for innovation and change. And all of these must be undertaken in full light and awareness of established principles of the child's physical intellectual, emotional and social development.

In each national situation choices have to be made by governments in light of current political will and commitment, planning capacities, absorptive capacity, availability of technical support and advice, access to complementary resources, human and material, and adequacy of existing infrastructures. UNICEF co-operation will be determined by availability of its own resources

and by the policies and recommendations discussed above. It is in the area of intersection of interests and concern that projects will be identified and supported.

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THE CHILDREN'S HOUR IN SRI LANKA

Statement by David P. Haxton, Regional Director, UNICEF South Central Asia Region at a Review Meeting on the 1984-88 Programme of Cooperation between the Government of Sri Lanka and UNICEF Colombo 2-3 June 1982

There comes a time, I suppose, in all these Reviews where UNICEF has to express its embarrassment for drawing so much attention to itself, and we should rather hope that the concentration in subsequent sessions of your groups will be focused more on children and what everyone should do about them—not just UNICEF.

In being asked to present some preliminary and rather broad conclusions that UNICEF has drawn from these sessions, I believe that the first thing that we should emphasize again, and not just as a matter of courtesy, is our very profund congratulations to a variety of organizations and people : Congratulations to Government and the political leaders of Sri Lanka for recognising the most valuable resource in the country and putting behind that recognition the will to move forward on serious improvement of the quality of life of children. Congratulations are also in order to the many representatives in this room who worked so hard and so openly,

and I believe so intellectually and honestly, to look at children in Sr. Lanka, analyse the situation, state the facts for what thay are and propose sensible alternative attacks to those problems.

Our Chairman stated at the very first session, and has repeated at every opportunity, that the objective of these sessions is to determine that any proposal made meet the criteria that it is part of a policy objective of the Government of Sri Lanka. Also that any proposal made fits UNICEF policy objectives. I believe from the UNICEF side that nothing we have heard falls outside our policy framework and what we need now is some time to reflect—to see how we can select and suggest to you those things that we believe would be the best recipients for the modest resources available from the Fund.

In doing that, I think I would be remiss if I did not point out that we might need, in more than is in the present documentation, some more specific evidence of priority and priority selection. Everything is important for children, of course, and all of us together do not have all the resources required to solve every problem quickly. Therefore we need some evidence of selectivity on priority, and this priority may be best evident in the various forms of commitment: political commitment, financial commitment, personnel commitment, and commitment to build into the process a monitoring and evaluation system which is demystified and in the hands of the planners alone, so that as progress does take place, or as progress has slowed down by some bottleneck, corrective action can be taking place without undue cost or waste of energy.

Another conclusion is that certain issues seem to have evolved, not only in the discussions but in the documentation. For convenience, I have grouped them into three sets :

The first set, at least it seems to me, might be termed "survival" issues. There is a serious issue of survival of children, which was very graphically demonstrated in our first session and I doubt if any of us have the intention of by-passing that issue. There are two related activities among others that directly can be used to address these survival issues:

—Improve aggressive diarrhoea management, both through regular, ordinary channels, and through extraordinary channels. I was happy to see home treatment as of equal importance as other treatments of rehydration and diarrhoea management. After all, that is where it strikes most often and since homes are never closed or locked like health centres and pharmacies, maybe we should put equal importance on this.

—The second is the horrible connection between malnutrition and infection. Perhaps alternative delivery methods could be designed to attack survival issues.

The second set of issues, it seems to me, revolves around, for lack of a better word, "approach" issues or "how to converge" issues. Some of these were mentioned:

—Concentration on area by geography. We had a brilliant outline of reasons for selecting area development this morning.

—Another approach is the primary health care approach, and I would like to return to this in a few minutes.

—Another approach is what we bureaucrats call "community participation" or "popular participation" approach. What we really are saying is that, left alone with modest outside help, most people do most things right for themselves. If that were not true, infant mortality rates would reach a thousand. So I guess what we are really trying to say is that "let's see what people are doing that's right and let them go on doing it that way, or to put it another way, in my own less-than-academic language, "if your machine is working, don't fix it."

—Another approach issue is to focus on young children, and by young children I include the elements relating to approaches to maternal nutrition, maternal health, family planning, child spacing, etc.

—Another approach is to improve infant feeding practices. I would like to make a small commercial here : UNICEF would

be in favour of improved infant feeding practices if there were no International Code. The Code is just an additional weapon as a plan to improve infant feeding practices, and this runs right through all existing permanent services. For instance, if you are now supporting hospitals or clinics which separate mother and child after birth, you are violating the Code. If you are now having training courses which do not include aspects of human nutrition and human nutrition improvement, you are violating the Code. Let us not worry too much about the Code and the international marketing of baby foods alone. There are other elements to improve infant feeding practices.

The third set of issues that arise, and I think this is really the heart of the issue, is related to what I call "Child development" issues : learning. Early primary education is sometimes more than just a transmission of knowledge to gain entrance to something else, but rather to infuse in young children those elements of human life which are required so that they can become dignified, participating, inquisitive citizens.

Another child development issue is maternal nutrition, and again improved infant feeding practices.

What are my Major Conclusions ?

—The first is that there is no doubt on the UNICEF side of the serious high-level commitment of the Government of Sri Lanka, and UNICEF is prepared to work with you in whatever ways that are mutually agreed upon to be the most effective and most efficient.

—Second, we are delighted that the Government of Sri Lanka is preparing a Country Programme for Children, not a Country Programme for UNICEF.

—The third conclusion is that, within the Country Programme for children, UNICEF will be able to respond only in part, of course, and much has to be done to determine the appropriate "mix" of that response.

—Fourth, we hope that the Government officials and others present will promote these same ideas to all other donors. To the degree that we can do that in conjunction with you, we stand ready to help.

—Fifth, is that the major programmes that seem to be required are in need of three considerations :

—We might have to look at them from both sides of the table to define them with more cost effectiveness in mind. I have mentioned some of these already.

—We might want to concentrate with regard to UNICEF Cooperation on key issues-with appropriate approaches in order that national energy will be released to "get on with it." Some of these issues seem to be related to early childhood learning and stimulation, primary learning, nutrition interventions of a variety of kinds, basic services in a convergent way—especially concentrating on prevention, and in that context a greater emphasis seems to be needed on sanitation, not just excreta removal, although that is important, because probably more children are dying, literally hand to mouth than we would like to realise.

—I believe that some of the programmes outlined could be enhanced by a combination of programme delivery techniques which are emerging.

One is communication : modern, effective communication. In other words, "go public." Isn't it interesting that most people only desire two products in their whole life—good health and good nutrition—and we haven't been able to sell them effectively since development started ? Could we use modern message communications more effectively ? I think we should try.

Second, we might use what I call "unusual channels" things that are there that we don't often think about using. School children can become development agents

for children, especially with regard to the early detection of impairments before they become disabilities.

My sixth conclusion is that the Country Programme of Cooperation between the Government of Sri Lanka and UNICEF will need more refining to see that it matches with your own country programme for children. As mentioned this morning, there is the need to improve linkages, not only between sectors but also within the same sector. In this connection, I am very grateful that many of our colleagues from the UN have been in attendance and have made their own comments and observations, and I hope that Government and all the other members of the UN family will keep the country programme for children in mind as priority for support.

My seventh conclusion is that I am very pleased to have been part of this process as observer. Sri Lanka is being observed by a number of countries, not just the UNICEF Executive Board, for your obviously outstanding progress so far, with balanced social and economic development, and with all the difficulties which we have frankly discussed. We are now in the next stage: the maintenance of this, making this more profound, and getting more people involved. It is nerve wracking to be centre stage, but it will be an exciting and interesting ride as we move togother into the future, and I am glad that you have asked me to be part of that ride.

Finally, in the small town where I was raised, there used to be a poet and one of his more famous poems had this reference in it:

"At the end of the day's occupation
When the sun is beginning to lower
There comes a pause in the day's occupation
That is known as the Children's Hour."

I believe very firmly that the Children's Hour has come in Sri Lanka.

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SOCIAL DEVELOPMENT IN THE THIRD DEVELOPMENT DECADE

Statement by Alexander C. Tosh, Principal Officer
at a seminar on "UNICEF cooperation
with non-governmental organizations in social development"
5-6 August 1981

Social Goals and Realities

On 19 July 1981, a group of Indian scientists meeting under the auspices of the Nehru Centre in Bombay issued a statement of which the following is an extract :

> "The gravity of our predicament is increasing day by day. While we rank high among the industrialized countries in the world in regard to the stock of manpower trained in science and technology, we are close to the bottom of the list in terms of per capita food consumption, longevity, health care and general quality of life. We have all the technology available right now within the country to give water, food, shelter and basic health care to our millions, and yet we do not. Something has gone wrong. The logic of planning and the logic in our socio-economic structure are at variance. Hence our failures and disappointments."

In a recent publication of the United Nations Research Institute for Social Development (UNRISD) entitled "Social Development and the International Development Strategy," development is defined as "both a process of economic growth and structural change stimulated by an international programme of resource transfer and technical assistance and as an inspirational ideal or myth for mobilizing people and resources." This may be a debatable definition but the subsequent burden of the UNRISD message calls the attention of the U.N. to what it sees as an approaching impasse in development. It asserts that amongst countries, groups and individuals in the developed world there is disillusionment with international development, efforts mainly as a result of the obvious disparities between the professed social goals and the realities which increasingly become apparent. In the developing countries themselves scepticism and cynicism are reinforced by the contradictions between proclaimed goals and what are perceived as the real objectives of the aid givers. The accumulating frustrations on both sides lead UNRISD to speculate that the "Development movement" will soon fade into history.

What the Indian scientists in the Nehru Centre expressed as the "variance between the logic of planning and the logic of our socio-economic structure," UNRISD saw as the "obvious disparities between the professed goals and the realities..."

The Many Causes

The reason for the gap between social objectives and real trends has many dimensions, not all of them discernible from a single viewpoint. They relate to the international order, societal structures, to administrative structures and to planning mechanisms and methodologies. Some of the most frequently cited are:

—Economic growth in the Third World has not been sufficient to permit significant allocations to social programmes ;

—International price fluctuations, debt burdens, and other pressures have forced governments to concentrate on crisis management ;

—The powerful forces of transational business and commerce frustrate major changes in development patterns ;

—Affluent minorities in the Third World implant the "consumer society" and entrench structures of power and production serving those minorities ;

—Expenditure on armaments and police establishments increases ;

—Dominant groups attach overriding importance to economic growth ;

—Many Third World policy makers regard human objectives of development as diversionary tactics of central capitalist countries and thus undermine their moral authority ;

—Expansion of social services in developing countries remains excessively dependent on norms and techniques from high-income industrialized countries thus precluding universalization ;

—Technological dependency is often generated by international aid ;

—Exhortations to the poor to limit their consumption aspirations and try to meet their minimum needs through aided self-help are bound to be ineffective when highly visible affluence contrasts flagrantly with extreme poverty and insecurity.

The Crisis of Management

In addition to all of these there is what the Bellagio Conference of 1976 described as a "crisis of management in L.D.Cs." The Conference concluded that Third World schools of management and administration serve merely as conduits for dissemination of received management wisdom from the U.S. and Europe, occasionally with minor adaptation to local conditions. They found that while "enterprise" management technologies have transferred

quite easily and have contributed to modernization of industrial development they have not transferred so successfully into the social sector. The planning and management of development projects (UN assisted or not) have not met the needs of the people who are the clientele of development programmes, the poor and deprived.

The Working group of Third World Management Institutes (which includes the Indian Institute of Management, Ahmedabad) has pursued this problem since 1976 on the four following themes:

(a) The challenge of the 1980s is to make structures of key development agencies more responsive to the people's own efforts to make productive use of local resources ;

(b) A learning process approach to development programming provides the framework for evolving programme designs out of involvement with the people and for building organizational capacity based on that experience ; it offers an alternative to blueprint approaches to programming, which implicitly assume that what to do is known and the organizational capacity to do it already exists ;

(c) The classical organizational and temporal separation of planning and implementation, and the assumption that organizational structures are policy neutral are major weaknesses in existing development management methods. In fact, relatively more successful programmes have been managed according to strategic management concepts;

(d) Agencies must build on, rather than undermine existing self-help capacities. This is people-centered planning and better diagnostic methods should be used to identify target groups, where they live, and what are *their* strategies for using available resources to maintain and advance themselves;

(e) Increasingly, pressures on resources calls for more intensive management of these resources. Such management is best accomplished at the community level by the people dependent on the resources. Government and other agencies have

to learn to work effectively in the development of community capacity to manage.

Closing the gap

The Working Group's research suggests (in broad terms, at least) ways in which the gap between objectives and reality may be closed :

(i) *respond* to people's own efforts ;

(ii) build organizational capacity based on *experience* ;

(iii) *bring* planning and implementation together in time ;

(iv) *build on* existing selfhelp capacities and strategies ;

(v) *rely on* community level management.

Scientism

Since time began, development has taken place through the processes of ecological and social interaction and of problem-solving. Scientific knowledge and scientific processes could be valuable assets in the furtherance of solution finding. However, they are often supplanted by a scientism which has invaded the thinking of UN organizations, many schools of management and administration and planning at various levels.

Scientism assumes that the processes of science may be applied without reservation in other fields, such as human development. Additionally, scientism often uses, or misuses, these processes to justify actions taken on the basis of preconceived theories. For example, data-gathering and surveying, ostensibly to establish knowledge bases on which patterns and general hypotheses are formulated, are sometimes manipulated to fit expectations. At worst they are indulged in as mere displacement activities. Induction was traditionally the hall-mark of the scientific method and the strict adherents to that tradition contrast statements about social sector and human development matters based on data and

enumeration with statements of all other kinds, whether based on intuition, experience, emotion, speculation, habit, or any other foundation, as alone providing sure and certain knowledge. This, in effect, is a misrepresentation of the scientific method as it has been understood by logicians, philosophers and scientists for a long time.

Science

The history of science records that theories have been arrived at in any number of ways : in dreams, in flashes of inspiration, even from misunderstanding and mistakes. Every discovery contains an irrational element. There is no logic of creation. Einstein spoke of the :

> "search for those highly universal laws from which a picture of the world can be obtained by pure deduction. There is no logical path leading to these laws. They can only be reached by intuition, based on something like an intellectual love of the objects of experience...theory cannot be fabricated out of the results of observation, but can only be invented."

While scientism assiduously diverts the "blue-print" development planner away from invention and intuition, falsely invoking objectivity and logic, science more often makes a start from existing knowledge, experience and hypotheses and follows a process of testing and refutation, finding out what can be improved, improving it, looking for further shortcomings that can be overcome and repeating the cycle over and over.

If development takes place through ecological and social interaction and by problem-solving, then the broad path to development would be from problem to problem, charting routes as progress is made, performing mid-course corrections as solutions are evaluated. In short, the most appropriate and scientific strategy for social development is action research; strategic management is the fitting control; inspired operators and innovators are the agents to catalyse change.

Jawaharlal Nehru, in "Discovery of India" wrote:

> "The scientific approach and temper are, or should be, a way of life, a process of thinking, a method of acting and associating with our fellowmen...The scientific temper points out the way along which man should travel. It is the temper of a free man."

Conclusion

Free man (when not meeting crises) has often shackled himself to bureaucracy, rigid enterprise management and the blandishments of R & D as the best, or even only, planning technology for human and social development. To this has been added the confusion of scientism. It is equally true of the UN and of government and it is rather unlikely that either can put a premium on boldness of imagination in problem-solving. Neither can accommodate the unforeseen, or the ever-present possibility of radical transformation of any conceptual scheme on which it embarks. They are unable to fall back and reorganize quickly when actions have unintended consequences. They do not encourage innovative and enterprising individuals and groups to exercise their talents without fear of retribution. This final charge against them is made in the statement by Indian scientists at Bombay :

> "...obscurantism and irrationality practised by a hierarchy of authorities has had the predictable effect of reinforcing retreat from reason. Voices raised against such a state of affairs get silenced."

If the "development movement" is to survive and contribute to mankind's betterment then it must explore the thoughts, aspirations and plans of the people and reinforce their efforts in both planning and implementing solutions to their own problems through their own agencies. All international and many national agencies and institutions protest that this is what they do. However, the results belie the protestation. The gap between objectives and reality is evidence of a failure in procedure.

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PROGRESS REPORT
1982

of the UNICEF Regional Director
for South Central Asia

Another year's experience in striving to strengthen the chances of survival and development of the 290 million children of the Region, underscores a major lesson: Success comes when resources, agencies and services coalesce within a community towards a common purpose and priority. This is predicated on a broad unity of ideas, attitudes and interests. The social tension generated in the process needs to be consciously turned into a creative force. This effort is a dual function of credible advocacy and demonstrably productive action—the outcome of which is to influence decision-makers and be beneficial to people.

Access to policies

The Region as a whole enjoys political stability, especially in the electoral sense. The political process, while presenting complex pictures, does indicate that a consensus around a priority for social and human development is apparently gaining. Thanks to current concern and historically valid policies, some of the countries, and some states in India, have been able to translate planned ambition, in part, into improved quality of life for more of

the silent majority. The level of political consciousness that would make this vast social segment articulate its demand for equity will come sooner or later. Such a trend would have more to do with the times than with particular political systems. Enlightened leadership will see in it, not the portent of turmoil, but a propitious start for the development of those who have waited the longest.

Too many to feed

Except for Mongolia, the size of national populations below the poverty line is still large. It varies from a fourth in Sri Lanka to around half in India and probably more in Nepal and Bhutan. Fertility rates are the highest precisely in these segments. Even in Sri Lanka with the most hopeful trend, the rate is much above the 'replacement rate.' That development is the best contraceptive is not a new insight. The conviction that poverty and ignorance are the real problems, is steadily permeating population policies. And the earlier explosive rates seem, from recent isolated reports, to be mildly abating, almost as gently as, and in inverse proportion to, the rise in the female literacy rate, now widely recognized as a major determinant of family size. Hopeful trends will be sustained if their pace picks up through wider knowledge and better control by people over their own lives. This would in turn be enhanced by reinforced will to tackle population problems.

Quest for a living

Given the rate of unemployment of around an eighth or more of the labour force, the migration into already congested cities is a cause for concern. While attention must turn increasingly to the care and development of children in city slums, efforts must still continue to create work opportunities in villages and to provide basic services to children of rural families. The concept and example of area-specific and people-specific socio-economic development is catching on in the Region—as a steady substitute for uncoordinated sectoral programmes of difficult viability. Here again, the transition to the alternative approach is taking time—for apparent want of clear agreement on the level and type of agencies best suited to promote the process.

The access of the poor in the Region to food cannot be taken to

have improved during 1982. Foodgrain production may in fact be less than in the previous year in India, Sri Lanka and Nepal. Prices are high in relation to purchasing power even where the rate of inflation has been moderate. Drought or flood or both have occurred in many areas, creating immediate and lasting problems. The consequent nutritional set-back especially to children may be serious, even largely unmeasured. Here again, a prudent approach would be to tackle the root causes—for example, by giving more people a stake in the land and its yield; by building nutritional concerns into agricultural policy and planning; by preventing the destruction of forests; and by planting, with discrimination derived from experience and research, trees that give food, fodder and fuel. What is interesting is that sensitive groups are active in these directions, both in governments and among people. Vested interests and diehard policies conspire to slow the pace of corrective action.

A matter of purchasing power

The adverse effects of the world recession continue to be harsh. Several industries find themselves virtually in a state of depression, with repercussions that leave a ripple effect. The dependence of nearly every country in the Region on other countries seems to have increased. A small country like Maldives which has had a running surplus of foreign exchange is straining to pay for much needed imports. In India, the external payments gap has widened, even though the domestic saving-investment gap has all but closed. The Sri Lankan economy is under stress due to high inflation, budgetary deficit and an adverse trade balance. While governments are trying to cope with the situation, the full focus of development programmes has not yet been made to fall on those people ground between their pre-existing poverty and current adversity.

Doing with less

Against this background and in the light of policies established by the Board, the UNICEF role in countries of the Region is fairly sharply etched. In the first place, a number of inter-related managerial measures have been taken to improve cost-effectiveness within UNICEF. Some of them merit a mention. The redeployment of

staff in a carefully dispersed pattern, was started over a year ago in India and has been completed during 1982. Outposted staff in Nepal are providing more cost-effective implementation efforts. A quicker and better response to local situations (emergent or endemic) has thus become feasible, without increasing the overall staff strength. Incidentally this accords with the devolution of responsibility and power that is currently happening in several governments.

A beginning has been made to improve programme delivery performance with regular and rigorous analysis in terms of programme and activity objectives; activities design; achievement targets; planned budget; actual achievement and impact; and expenditure. This will lead to more effective programme monitoring, easier course correction, better guidance in relation to policies, priorities and resource flow through annual, medium-term and long-range programmes.

Annual programme performance reviews are held in each country. These are exercises which review all elements which bear on UNICEF delivery; administrative budget; supporting services budget; personnel staffing; programme progress; government policies; new trends; and programme management issues. The programme related issues are discussed in joint UNICEF-Government groups. In *India*, this year, the review revealed a number of ways to improve delivery; in *Afghanistan* it resulted in practical application of resources in specific areas; in *Nepal* (following the Executive Board approval lastyear) it has resulted in concentration on implementation, especially of nutrition and primary health care activities; in *Bhutan* and *Maldives*, specific plans of action for 1983 have been produced; in *Sri Lanka* the results are contained in a proposal of the Executive Director to the 1983 Board.

Some positive signs

The broad directions of UNICEF activity in South Asia during 1982 are described in the seven country reports. There is clearly no easy or quick way for most of them to break out of their historical trap of poor incomes and low development at a time when global economic recession is interspersed with natural and man-made calamities. Having said this, the positive signs must be

underlined :

—The priority for children (and their main reliance, women) is moving up on the policy-making scale, in each of the countries. Plans to meet their special problems find a new and welcome mention in government policy documents. Programmes for children are finding more and more allies among influential government leaders. This is indicated by the innovative activities in *Nepal*; the policy statements and subsequent action plans revealed in the country approach to children in *Sri Lanka*; the 20 Point Programme in *India*. The diarrhoeal disease control efforts in Maldives and the creation of a special unit for focus on primary education in Sri Lanka are other examples. UNICEF is encouraged by this trend to which it has made its own modest contribution.

—Current circumstances and practical experience both argue strongly against strategies that are cost-intensive, centralized, bureaucratic, and unvarying. Rather, governments are beginning to encourage sub-national variations, alternative programme approaches, reliance on local low-cost answers, reposing increasing responsibility (and power) in the community, releasing information and technology for use on people's initiative and in some cases, taking them fully into confidence through the stages of identification, planning, execution and evaluation. The small farmers scheme in *Nepal* and the decentralization process in *Bhutan* and the women's development activities in *India* are some examples. Present backwardness is no bar to these brave, new departures; indeed it fully justifies them.

—The congruence of these nascent national trends and the UNICEF approach to basic services, places a new responsibility on UNICEF, beyond the traditional catalytic role. It has to be a role model as necessary. Change as a law of life applies to UNICEF as well.

A word or two about last year's goals

In the progress report to the 1982 Executive Board we proposed to continue to encourage a thematic approach to key elements of

programmes for children. A word or two about progress :

Improved infant feeding practices

In each country major promotional efforts within the country programme are underway. Progress is steady but slow on adoption of the International Code of Marketing of Breastmilk Substitutes. However, emphasis is placed on what can be done now on each element of the code within already approved country programme plans : i.e., to promote maternal nutrition; to encourage continued breast feeding and to circulate among leaders, the medical profession and others scientific information on the values of breastmilk and breast feeding; to discourage separation of mother and child at birth—especially in any centre equipped by UNICEF; to search for locally available weaning foods and to promote their wider use; to encourage more media coverage for these issues. The new proposals for Sri Lanka emphasize this. The country programme in Nepal places this in priority.

Infant nutrition

If there is one theme that runs like a thread through each country programme, it is infant nutrition. This springs from the logic of the prevailing situation and no country, even Mongolia which has satisfactory indicators of child wellbeing, can afford to ignore the fatal threat of malnutrition to the newborn. In the South Asian situation, the programme thrust has to fall as much on intermeshing preventive areas like diarrhoea control and prevention of deficiency diseases like anaemia, blindness and goitre, as on promotive aspects such as proper practices in infant feeding.

A regional task force meeting monthly encourages and reviews promotive action. The Sri Lanka Government has accepted a National Code for marketing breastmilk substitutes. This is being followed up by Consumer Protection Act. A strong outline of a similar Code for India has been under discussion and some regulatory steps are soon expected. Public interest and government concern are growing in this area in all the countries and should lead to some effective action in time for the next World Health

Assembly. The aim of the currently supported efforts is to :

—assist the rural areas in preserving the traditional practice of breastfeeding;

—reverse the inroads of bottle feeding in the urban periphery;

—inform and empower mothers everywhere about proper, inexpensive weaning food supplementation.

The well-known resistance to change is being anticipated and faced through widely publicized argumentation through every possible media.

The focus on nutrition instantly summons to its support attention in allied areas like relevant education, primary health care including immunization, production of appropriate foods, safe water, sanitation, appropriate technology, investible resources of many kinds and participatory action in a decentralized framework. Nothing less will break through existing barriers to change. Less directly, yet equally importantly, other interventions are called for over a wide spectrum of programmes relating to employment, women's income generation, land ownership, rural credit, housing, family planning, literacy, communication. Even a country as progressive as Sri Lanka in social and human development is not free from serious malnutrition especially among children and mothers.

Diarrhoea is not for dying

The smallest country in the Region, Maldives, had a major (Shigella) epidemic in mid-1982. This was controlled in a remarkable combination of resources and manpower under the personal guidance of the President. There is however an almost continuous incidence of endemic diarrhoea, and an avoidable dependence on scarce doctors, drugs and hospitals, resulting in death and suffering, enhanced malnutrition and depressed productivity, reduced tourism and depleted foreign exchange. The alternative being promoted in all countries with UNICEF support is a behavioural change at the mothers' level in favour of oral rehydration therapy combining emphasis on education, home treatment *and* increased

production of and greater availability of ORS. Visual aids to support these arguments have been produced. We are proposing that public communication by every conceivable means be pressed into service—word of mouth, posters and pamphlets, radio and television spots, sound and slide sets, school lessons, popular songs, messages by health workers and community leaders. This approach is gaining ground in India, as well as among the medium-sized countries. The chances of diarrhoea control in the home, where it strikes, should improve, once the new 'culture' (or, way of looking at things from the viewpoint of those in need) permeates other child-related programmes like the Integrated Child Development Services (ICDS) of India—an ambitious, many-sided countrywide programme which if it develops properly, would approximate to the UNICEF concept of basic services strategy.

Anaemia to be tamed

There is a new confidence in this part of the world about pushing the old idea of fortifying common salt with iron, as an answer to anaemia, estimated at 40-60 per cent among pre-school children in India. A survey in Sri Lanka shows high prevalence of anaemia in all groups. In countries like Afghanistan, Nepal and Bhutan, the situation is unlikely to be very different. While poverty-related causes of anaemia need to be tackled in a combination of ways, the opportunity to introduce iron fortified common salt has somewhat brightened with the recent positive results of studies on community use of fortified salt. Efforts to influence government policies and public opinion are kept up.

So to goitre

The extent and consequences of endemic goitre in South Asia remain under-estimated, even when understood. Surveys about prevalence are still in progress. Findings so far are deeply disturbing in that thousands of children continue to be born to become cretins. Again, the answer is known; the prevention is relatively low-cost iodized salt. Early detection through radio-immunoassay of a blood smear (that can be sent by post!) has also been perfected by local researchers. UNICEF is active in modest ways —including support for iodinated oil injections during pregnancy in endemic areas. India, Bhutan, Nepal, Afghanistan are all heir to

this disease. Sri Lanka, largely unsuspected, reports its prevalence in the south west. Old ongoing programmes of salt-iodization in India (40 million Indians are estimated to be affected by goitre) are to be upgraded. The UNICEF response to the goitre problem has until recently consisted of funding salt iodization plants. This has been modified, but not reversed, to put the accent on persuading governments, the medical profession and teaching institutions that goitre is *not* a cosmetic problem and should become a matter of national priority in terms of urgency and resource allocation. Indeed, goitre control programmes as they exist need to be re-shaped, an exercise in which UNICEF is a keen participant.

Promotion of the *basic services approach* and *primary healh care* continues. In Nepal, new ventures are underway and the WHO/UNICEF teams are working closely together to help the Government sort out problems, test approaches and learn as progress takes place. The ICDS programme in India is moving forward.

Decentralize and develop

In pursuing preventive and promotional nutritional goals, a recurring lesson is the need for a dencentralized design for largely autonomous action resulting from enhanced knowledge and changed attitudes. In this context, one of the more hopeful signs is the policy of several governments to devolve both authority and responsibility to formations close to the people—to the panchayats in Nepal, to the districts in Bhutan and Sri Lanka. Nothing would stimulate the UNICEF strategy of basic services (and the allied approaches of primary health care and relevant learning) more than this decentralizing trend becoming a stronger feature of the landscape of South Asia. For that the time is perhaps ripe.

New Delhi, 30 November, 1982

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PRIMARY SCHOOLING—AN INVESTMENT IN HUMANKIND

Presented by Alexander C Tosh, Principal Officer
UNICEF, South Central Asia Region
Seminar on Educational Innovations in School Education
Pune, India, 9-18 December 1982

Primary schooling may be regarded as the first of successive levels of schooling—the elementary or fundamental level on which secondary and tertiary levels are founded. In another sense, the adjective "primary" may be understood to signify that which is first in importance. The latter connotation is less often the one given, even though there is much evidence to support the contention that it ought to be. One purpose of this paper is to draw attention to the arguments, economic, social and educational which support a view that primary schooling is perhaps the best but certainly a sound investment in any nation's economy, yielding a high rate of return; that it has a nuclear role to play in human development; and that it provides an avenue to equity and social justice. A further purpose is to suggest ways in which primary schooling may be modified and adapted to meet developmental needs and provide an adequate and appropriate preparation for life.

Built into the constitution of every developing country (most of which became independent in the 1950s and 1960s) was a clause which enshrined the right of every child to schooling. In part, this provision was a derivation from the liberal tradition in which, for the most part, the early leaders had themselves been educated. (For example, in India, Nehru advocated education as being "good" in itself and a requirement for the development of the "whole" person. In many countries the political leaders were products of mission schools which combined in their curricula the values of service to others and academic excellence.) On the other hand, the "human capital" theory, which almost invariably accompanied independence, demanded that workers be prepared in schools for the industrialization which was felt to be the prerequisite of development. For whatever reason, in a series of meetings of Education Ministers convened by UNESCO in Karachi (Asia), Addis Ababa (Africa) and Santiago (Latin America), country after country drew up objectives and schedules of school expansion which were to challenge them continuously throughout the succeeding decades.

Strenuous efforts were made to attain universal school enrolment. Primary enrolment doubled in Africa and Latin America; in Asia it rose by 80 per cent. At other levels of education, the proportional increases were even higher. There were major achievements in linear expansion, but in most countries the rate of increase could not keep pace with the rapid growth of populations and increasing demands on national budgets. And in the effort to attain the targets, standards sometimes deteriorated: teacher education went into decline; school environments became less conducive to learning; facilities became fewer, and so on. In general, it was the private schools, available only to the elite or the comparatively wealthy, which were able to maintain the highest standards.

The expansionist policy was justified to a great extent on the grounds that economic backwardness was due to a dearth of manpower skilled in the crafts and trades of industrialized nations; that the systems, content and methodologies of Western education were transferable to other countries; that skilled manpower is schooled manpower (a natural assumption since the coveted technology was also a product of the West). Such was the

immediate need and such was the mood of the times that these assumptions were accepted wholesale. Often in the name of equity of opportunity for the individual and sometimes to foster national sovereignty and pride, enormous investments were made in linear extension of colonial systems. Large-scale curriculum projects flourished, introducing the subject matter of modern science and technology but more often than not presenting it in conventional ways—in institutions modelled in the classical mould and using out-dated educational methods. The developing world was in a hurry and it was not the time for the critical voices of caution or moderation to be heard. The wisdom and appropriateness of the indigenous educational philosophies were increasingly disregarded in favour of theories developed elsewhere. Implicitly or explicitly, the argument in favour of primary schooling was increasingly seen as a direct economic investment in the stock of human capital.

Not all the basic assumptions were necessarily at fault nor was any one of them necessarily totally false, but with a few modest exceptions, they led to financial expenditures rising faster than total enrolments, severe budgetary problems, graduate unemployment, the expectations and plight of secondary school leavers unwilling to take on low-status jobs but not qualified for higher ones, the unpreparedness of primary school leavers to enter the world of work with enquiring minds and the capacity to acquire a diversity of relevant skills. In addition, the inexactitudes of planning which for the most part (and inevitably) failed to match projected manpower needs to educational opportunities, resulted in disparities between needs and availability, and the absorptive capacity of the labour market. Alienation and disgruntlement characterized thousands of "educated" job seekers. Above all, perhaps, the human capital theory undermined what had previously been the strength of many traditional initiation procedures—the acquisition and inculcation of habits, attitudes, values and discretionary powers which are the social foundations of communities and societies just as surely as is their economic status.

In recent years, research scholars have re-examined the economic argument in favour of schooling and while some of the factors supporting the earlier argument do appear to retain a claim to continuing validity, there has been considerable re-thinking of

the overall emphasis on the direct linkages between projected manpower requirements and the provision of learning opportunities in schools.

Schooling *does* appear to result in more worker productivity, whether that productivity is considered as relating to the individual's employment in a "job," or to corporate production output outside the formal employment sector. This appears to be beyond dispute. However, increasing his or her cognitive skills through extended schooling does not necessarily enhance an individual's chances of entering high-status employment. It is not the extent of knowledge which determines a worker's ultimate level of job attainment. Even at tertiary levels, graduate grades are only minimally predictive of worker's performance. School performance (measured in terms of cognitive achievement) appears to have no significant bearing on individual earnings in later life.

However, it does appear that achievements in the non-cognitive domain *do* positively and directly affect earnings. At the lower job levels, attributes such as punctuality, obedience, respect for authority, etc. are much favoured by employers; at higher levels initiative, self-reliance, decision-making ability, etc. are most rewarded in employment in the formal sector of the economy. The human capital theory still has validity but for reasons not fully understood earlier. There is not necessarily a *technical* relationship between the education required for the job eligibility and the occupational skills needed for effective performance in the job.

One of the most interesting conclusions of much of this recent research is that positive changes in attitudes and behaviour of the kinds mentioned above are achieved even in schools of very low quality. Perhaps in many cases this is due to the interaction with peers and their influence rather than to the contribution of teachers.

The economic argument appears to hold good for communities and societies also. For example, from 18 studies in 13 low-income countries in 1980, it was concluded that in 80 per cent of the cases examined, the relationship between years of schooling and agricultural output was positive and statistically significant. Four years of schooling increased output by about eight per cent.

However, the researchers concluded that education is not sufficient in itself; there has to be a "modernizing" environment e.g. equipment, new roads, improved strains of crops, etc.

A study quoted in the World Bank's Education Sector Study of 1980 provides evidence that education increases productivity individually and collectively. In 20 countries the rates of return on education are significantly positive: 12 per cent, or better. The average rate of return is significantly higher on primary education (26.2 per cent) than on secondary (13.5 per cent) or on higher education (11.3 per cent). The World Bank Sector Survey Paper concludes:

> "Arguments of economic efficiency...support continued investment in primary education. Some general formal schooling seems to be necessary for further training; it provides skills in communication, mathematics and science necessary in a modern economy. Educated workers are achievement-oriented, more self-reliant, more adaptive to new situations, and above all more trainable. To improve the external efficiency, therefore, it is necessary to expand and improve efficiency of at least first-level education."

In brief, therefore, the economic argument in favour of primary schooling is as follows:

(i) The main case for investment in primary schooling is that it makes people more productive at work and in the home. Far from being an obstacle to higher rates of economic growth, it helps to achieve them.

(ii) Evidence suggests that the economic and social returns to investment in primary schooling in most developing countries are higher than other forms of national educational investment.

(iii) In farming communities, with high illiteracy rates, primary schooling provides an investment opportunity which should have high priority on economic grounds.

(iv) Expenditure on primary schooling is not only a more attractive investment in many countries, but is a means of increasing the

incomes of the poorest people without overtly upsetting social norms.

(v) Changes in attitudes and behaviour are achieved even in schools of very low quality.

The economic argument is persuasive and important but it is the non-economic effects of primary schooling which impinge most directly upon the concerns of UNICEF. While there is a clear economic case for investing in primary education, the benefits of which are now measurable in terms of rates of return, input/output ratios, cost effectiveness and other indicators of profitable financial investment (all of which have become the gods of development planners), there is an equally strong case to be made for the effects of primary education on human development. This is a much more complex argument and not reducible to objective assessment using numerical indicators. It is based upon the synergistic and mutually supportive effects of schooling and other services upon social objectives. It is this return from investment in primary schooling which gives it a special interest for UNICEF. Primary education, from UNICEF's viewpoint, is a social rather than a pedagogic concept.

UNICEF's four major areas of concern are child survival, protection and care of the mother and child, improvement of the home and family environment and preparation of the child for life. It is believed that education has an interactive and strengthening effect on all activities deriving from these concerns. Child survival is better assured when the mother, family and health worker adopt enlightened sanitary and confident practices in ante, peri and post natal care. An increase in the years of schooling of females affects the "biological supply" of children by raising marriage age, reducing numbers married, and by enabling absorption of knowledge about child-spacing and family planning. Education directly affects family size, health, nutrition, literacy and culture—all of which influence child survival.

The protection and care of the child similarly depend upon the creation of awareness and enlightenment. The knowlege, skills and capacities which enable families to improve the nutritional content of diets, correctly feed and wean their infants, diagnose

ailments and distinguish between those they can treat themselves and those which call for referral services, identify impairments at an early stage, present their children for immunization, protect them for exploitation, accident or the blandishments of strong commercial interests, and so on, are the outcomes of learning opportunities and experiences which may be provided in schools. Here again, as with the improvement of economic status, there is a core of knowledge and information which may be acquired but it is the inculcation of desirable attitudes and values that will bring about the better nurturing and cherishment of the child and the better preparation of responsible and capable citizens.

Learning and education in themselves are not enough to bring about the changes in survival, protection and care and the embellishment of the physical environment—all of which support human development. But education can play a central role in all of them and the content, systems and technologies of education can be deployed as the catalysts of a modernized environment. Clean water supply is essential to good health, but in itself will not guarantee it. An increased food supply will not necessarily affect the nutritional status of children. Availability of latrines is not sufficient to ensure sanitary surroundings. In all of the activities related to the planning, installation and maintenance of services, there is a learning element. Additionally, education may have a co-ordinating role in any provision of amenities which directly involves families and communities. We have already seen also that education makes a direct contribution to the improvement of economic status.

The traditional role of education is, of course, clearly recognized in the preparation of the child for life. The roots of the word itself are in *educare* and *educere*, the Latin "to rear" and "to lead forth." All societies in all ages have afforded learning opportunities of some kind to their young by which the children were initiated into the skills and requirements of survival and adult responsibility. Regrettably, in recent times, the learning experiences are not always selected or designed with consideration for their ultimate relevance to the life which the learner will lead in future years or to the needs of the community and society. In modern parlance, the aggregate of learnings is the "curriculum" and curriculum has

sometimes been ill-conceived as merely a "package" of knowledge largely unrelated to the learner's environment or the world of work. Where such linkages do occur, they rarely give equal emphasis to the affective learnings without which the cognitive learnings have limited currency.

Even when curricula are relevant and balanced, educational planners tend to develop them in isolation from modification of the systems through which curricula will be provided, or they fail to adopt educational technologies which will adequately support them. Thus, for example, there have been many attempts to introduce agriculture to the curriculum—a desired departure—by treating it as a traditional school "subject," time-tabled (inevitably considered inferior) and using the methods of "chalk and talk" as the method of transmission of knowledge and skills. Thousands of overgrown and derelict school gardens testify to the failure of this approach.

It is essential that whatever the learning opportunity to be provided in order to prepare the child for life, it be examined carefully from all three points of view: content; systems; methodology.

UNICEF concerns embrace all of these factors. UNICEF sees education (and particularly primary education) as an element supportive of UNICEF's own involvement with Governments and others in matters of child survival, protection and care, the improvement of family and community environment and preparation of the child for life. It is all-pervasive, cross-sectoral, supportive and inspirational in all other developmental endeavours. It is from this point of view that UNICEF takes its stand on behalf of children. The economic argument is powerful, but less powerful than the social one which projects education as the force which imparts impetus and momentum to the development of humanity.

The final argument in favour of universal primary schooling is that it has a levelling social effect. A widely held view of schooling is that it enables the ruling elite to maintain its position of privilege and power. Even the transmission of knowledge from generation to generation may be used to protect the position of ruling classes and maintain social stability. Restricted enrolment

in schools, the retention of sterile curricula unrelated to life, perpetuation of "inert ideas," are all means of maintaining the *status quo*. In India, the early educationalists and other thinkers were acutely aware of this. Compulsory education was introduced in Baroda as early as 1906; Gokhale moved a resolution to make elementary education free and compulsory as far back as 1913. Gandhiji published his similar thoughts on education as early as 1908, propounding learning through doing and forcefully rejecting intellectual training which is altogether unrelated to manual or physical work. All these early intellectuals recognized the egalitarian potential of schooling.

The primary school's potential is great. The system employs more personnel than any other similar sectoral agency. It has access, direct and indirect, to more homes and families than has any other single institution. It can be condemned in terms of its record on its structures, its processes, its relevance or standards, but to recommend its rejection or abandonment is to misunderstand its essential, deep-rooted relationship to mankind and its societies. While there is need for alternatives to provide opportunities for the educationally disadvantaged of all ages, the primary school still holds out the best hope for the future—but a school modified and reformed on the basis of sound socio-economic investment.

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ICDS : AN EXERCISE IN HUMAN DEVELOPMENT

Statement by David P Haxton, UNICEF, Regional Director for South Central Asia at the ICDS National Convention at New Delhi on 10 January 1983

ICDS is a major concern of UNICEF, though we are a modest partner in it. We see it as the most important means to reach millions of children and mothers who are caught in the multiple grip of endemic nutritional deficiency, economic hardship and recurrent 'natural' disaster. It represents an idea that has been in action for six years now. The pace of its expansion, the experience of its working in various settings, the scope for enriching its concept and content and the political priority given to it hold out the hope that ICDS *can* make a vast difference to infant mortality and to the quality of child life in our own time. We have come to this National Convention to share and strengthen this optimism, mainly by listening to and learning from all of you who are intimately involved in ICDS.

UNICEF is impressed by the pace of expansion of the ICDS coverage. That increases the responsibility of all the partners to see that each project fulfils its intended aims (and none fails) in terms of the services, their quality, the beneficiaries and the benefits.

We believe that a stage has been reached for the scheme :

—to consciously harmonize content enrichment with spatial expansion ;

—to broaden the spectrum of its services as widely as the complex of needs of children;

—to enhance its thrust with support of all those in each project area working for children and mothers and, for this purpose, to look beyond the scope of its own financial budget;

—to be bold and flexible enough to try out strategic variations to fit local opportunities for resource utilization and people's involvement;

—to monitor the impact, in terms not only of facilities, expenses and supplies but also of indicators of quality of life.

In all these and related directions, UNICEF is ready and eager to cooperate in every way it can. And I would like to devote the remaining minutes of my address to sharing with you some ideas that appear relevant to our common concerns and also feasible to be put rather soon into practice.

Consider the process of identifying the families that come into the ICDS purview. Income, as observed from domestic circumstances, is a usual criterion; and a good one at that. Would it be possible to directly identify malnourishment, or other health-related problems, in the expectant and lactating mothers, infants and young children ? I should think this could be attempted in more than one way :

—through a strong link between the anganwadi worker and the voluntary or official health worker :

—by providing, wherever possible, suitable space at the anganwadi for health check-up of mothers as well as children;

—by health education of mothers and prospective mothers so

that they may themselves identify their health problems and seek answers to them; and

—through carefully choosing the agents and the mechanisms of selecting the beneficiaries.

Let me touch on an allied area—what is usually called 'motivation.' An area is chosen, a project is set up, funds are found, facilities are created but how do we ensure that mothers and children—those that are most in need and at risk—come to the anganwadi, remain there and make it a part of their living? How do we lift ICDS from an experiment in social welfare to an experience in social development? Can the anganwadi be made the focus where women could discuss their problems and find ways to solutions? Where they could just meet much the way they used to, around the village well? Where the government official, or a voluntary agent could go to learn about the condition of children and women?

There are, as you know, projects where the local people have come forward on their own to provide the land or help in putting up the building for the anganwadi. There are Anganwadis on whose verandah women work on their sewing machines—for the benefit of their children. Can the activities around the anganwadi expand—on people's initiative—beyond the conventional content of ICDS, so that the original components become stronger and more viable? This is a possibility which I believe could be pursued, project by project, by the State coordination committees. They have the influence and the means to make this happen.

Nutrition is obviously basic to the success of ICDS. Perhaps there are problems in ensuring the quality of the food that is made available at the anganwadi. My own knowledge on this aspect is limited, but I have a feeling that the answer lies in *openness* of functioning. This is a precondition for accountability as well as participation. And the condition will be met only if people's minds are prepared, so that they understand and accept the programme and keep it alive and going. I am told about projects where mothers come and help the anganwadi worker in providing the services. Some bring along extra food and vegetables from their

own small patch of land. This is the culture with which we should deliberately try to permeate ICDS.

One of the problems with which ICDS seems to be grappling with is the operational integration it seeks to establish with other public services, particularly the systems responsible for primary health, functional education and basic sanitation. A typical outcome of this difficulty is the less than satisfactory progress towards universal immunization against the six common childhood diseases which continue to take a huge toll in child health and child lives. It is rather ironical that we have the technology and a social-institutional infrastructure (in the form of ICDS) and yet results are slow in coming. The answer, I guess, may be to make ICDS, in measured steps, less of an official institution and more of a social organization.

That brings us to the question of training, the needs and the capacity, its content and quality. I am happily aware of some excellent foundational work done and the strides made in training of hundreds of project officers and thousands of anganwadi workers. Yet this is, in our perception, still a problem area. The future of children of the marginalized segments of the population will be assured, once we succeed in selecting and training the right kind of anganwadi worker, who is of the community, works for it and shares its life. This is perhaps *the key* to the success of ICDS. Indeed the benefits reach farther : A thousand ICDS blocks will have trained and gainfully employed a hundred thousand women from low-income groups who may have otherwise remained unreached. The significance of this constructive process is as much social as economic. And that devolves on all of us a tremendous responsibility for adequate and timely training. Indeed this concern squares with the current emphasis on enhanced quality and outcome.

At this stage, I would like to place before you some suggestions to make the anganwadi the vehicle of a number of badly needed interventions on behalf of the deprived child. None of the suggestions is new, but all of them call for renewed application.

Let me begin at the beginning. Before development can start, disability has to be stopped. Today we know that most of the common disabilities can be barred at the threshold—if we start

with pregnant mothers and early childhood. Can we press into service, through the ICDS channel, every facility available in the block and not merely those budgeted under ICDS—for expanding the work of early detection and prevention of childhood disability? Using modern concepts of education on health, nutrition and environment, can we create an interest in school children to look with empathy for incipient impairments among themselves? I would like to stress that the weakest link in the needed chain of action is the apathy, unconcern and skepticism of adults in responsible positions—who do not believe that school children are concerned about one another; who do not see what anganwadis can do to promote the consumption of iodized salt against goitre (which affects 40 million people of India); or of iron-fortified salt against anaemia which limits the potential of even more. So, should we not promote every possible method and channel of communication—including advertising—to bring awareness and sensitivity to public functionaries, to encourage voluntary organizations to be more enterprising than they are today? Communication seems to be of the essence and, as we have just noted, there are audiences—apart from mothers in village and slum—who need to be reached, in offices and institutions!

For this, time seems to be ripe. Chambers of Commerce have, to my knowledge, shown interest in supplying iron tablets to children of the poor. Private firms are conscious of their social responsibility (in the interest of their own viability through worker productivity); and some of them have departments for social and human development. They are keen to establish an identity with their present and prospective clients. They have the money, they have social influence, they like to invest in goodwill through socially useful ways. I am aware that government procedures permit tax exemption for expenses of this kind. My plea is that we try and derive the most from this opportunity. We must make industry our ally in reducing infant deaths, child malnutrition, female illiteracy and involve them in a variety of fields—water supply, health, women's income generation, environmental sanitation, recreation, shelter.....Perhaps private companies could adopt ICDS blocks, the urban ones for example, either *directly* or through organizations like Rotary, Jaycees, Lions and the several genuine and experienced social work organizations in nearly all parts of India. We could make it possible for them to work for the ICDS

aims, leaving enough room for their innovative, spontaneous, productive participation. I have reason to believe that this approach would work and also save the government some money!

Nutrition is a primary concern of ICDS but poor infant feeding practices are the bane of much of the developing world. And if you look at these misguided practices—which go against both traditional wisdom and scientific temper—you will realize how severe an obstacle they present to social and economic development. I would like to emphasize just three dimensions that I believe should be major ICDS concerns. These are :

—The protection and promotion of the natural traditional practice of breastfeeding which is under threat from ignorance and irresponsibility.

—Simple procedures at home (like feeding a child having diarrhoea with a solution of sugar and salt in water and with normal food) for managing the consequences of child diarrhoea which kills 5 million children under 5 years, each year in the developing countries. This adversity is significantly related to the growing practice and fashion of artificial infant feeding; and thirdly.

—Promoting and supporting appropriate feeding during the period of weaning—mainly by informing, training and enabling mothers in the use of appropriate, local, low-cost foods, their preparation at home, and timely introduction in the diet of the child.

None of these measures requires large investment. Indeed a poor family can afford these, and nothing else. And I cannot see a vehicle more suited than ICDS at the anganwadi level to reach these messages to mothers and families in villages and slums. But I must enter a word of caution here. Insensitively or unprofessionally handled, communication can produce contrary effects. Messages have to be carefully framed and put across with genuine understanding of, and consideration for, pre-existing attitudes, beliefs and practices.

I believe, however, that the problem is not insurmountable in India with its considerable experience and expertise in the field of

communication. The point is that ICDS must open up to new ideas and methods in its conceptual and programmatic dimensions.

Before I conclude, I would like to mention an opportunity that is being availed of, but perhaps without deriving the full potential. I understand that half the child-growth charts produced in India go to ICDS blocks. In the absence of full information, I am not sure if we can describe this as mass-use of the growth chart. An intelligently designed card, which even an illiterate mother could use, would be one of the best ways for timely detection of creeping malnutrition—which may go unnoticed even by mothers. Early correction could follow early detection. And neither would be expensive. UNICEF, for its part, would be glad to support experimental and demonstration activities in this regard—particularly to redesign the growth chart to make it more functional for mothers than it is today.

I would like to conclude on an optimistic note. ICDS is poised not merely for expansion but also for qualitative change. The increasing coordination between the State governments and the Centre signifies that it has the necessary political backing and that it has come to stay. But an idea survives to the extent it is able to evolve in response to people's needs. As we have noted, ICDS is evolving in several ways—for example, making itself more open and better known; allowing itself local variations in keeping with prevailing circumstances; encouraging participation by non-government agencies. These are welcome signs of change.

We of UNICEF also look forward to the time when ICDS would virtually eliminate its dependency on sources outside the community. We have two main reasons for this ambition :

—No community is too poor to care for *all* its children.

—Basic services can seldom be generated, much less maintained, from outside the community on a viable basis.

In this perception, may I express the hope that ICDS will evolve over time *from* a government programme with people's participation *to* a people's programme with government participation ? The children of India deserve nothing less.

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PARTNERS IN DEVELOPMENT

Statement by David P Haxton, UNICEF Regional Director for South Central Asia
at the National Seminar on the Role of International Agencies
In Social Development
at the National Institute of Public Cooperation and Child Development
New Delhi, 18 January 1983

This Seminar has not come too soon in the Third UN Development Decade. As you know, the one lesson brought home by the first two decades is that economic growth is not the same as national development. This perception has been reinforced by the International Development Strategy for the 1980s which links fully, and for the first time, social objectives with economic goals.

This strategy is clearly under threat—from the continuing world recession, coming in the wake of soaring costs of energy and of other essential goods ; the slowing down of economic growth ; the rising graph of unemployment ; and the danger to the ecological balance. The burden of all these falls unequally between countries, and within a country. For instance, the concurrent economic crises reduce the resources available to governments for social services on which poor people are especially dependent. International development assistance is being restricted while the need for it is more desperate than ever. What is worse, the erosion of benefits *to* the poor tends to reduce the capacity *of* the poor to

support themselves. We of UNICEF believe that this challenge can be met by reaffirming the very elements of the threatened strategy of development, by relating economic aims to wider socio-political goals.

This is the context in which more and more people seem to agree on the need for a set of complementary policies to be applied on a global scale and in a concerted way—increasing employment, providing basic services, reducing inequalities (of income and wealth; and of status and opportunity) ; applying available resources in the most cost-effective way ; and finally raising the productivity of the poor. For this to happen, economic inputs have to be matched by social inputs like relevant learning, primary health care, basic nutrition, safe water and sanitation. The focus thus shifts from linear growth to qualitative change, behavioural change and to human development. In the perception of UNICEF, the highest priority should naturally go to developing the human resource from its earliest stage.

It is not enough that we set our goals. We have to be clear about the practical implications of attaining them in a given national context. I suggest that this be considered as one of the concerns of the Seminar, so that it becomes easier for us to see the role of agencies in development—international or national—as *participants* in a social process. Perhaps, in this Seminar, we can reveal—and further explore—ways in which economic and other resources may be used to prime the kind of development process that we advocate on behalf of the poor majority in developing countries (and for the poor minority in the developed countries).

Keeping in view the theme of the Seminar, perhaps it is best for me to start by sharing with you, in brief, the policy and experience of UNICEF in relation to non-governmental organizations.

As UNICEF has an extensive, long-standing and fruitful record of cooperation with many of them, I hope our relationship will have relevance to the role of NGOs as partners in development.

Among the more important and active supporters of the development objectives of UNICEF are a number of national and international voluntary organizations—professional, development

assistance, service, religious, business, trade and labour. Their role becomes crucial, especially in a plural society, as the focus of development shifts *from* progress in aggregate problems *to* the fate of the destitute human being. It becomes the primary function of development, in a poor community, to meet as a priority two sets of needs of the deprived individual : One, the material needs like food, nutrition, health, education, housing, development and income; and second, certain non-material conditions which the poor need (and, more often than not, are denied) : the opportunity for self-reliance, participation, self-determination, security, identity and freedom. This dual dimension explains, in part, the known UN emphasis on human and social development side by side with economic progress.

It is, therefore, natural for UNICEF to look towards NGOs as a major channel for advocacy, for influencing public opinion on behalf of children and for increasing public participation in mobilizing resources as well as in putting them to use. We seek to promote this aim generally and in specific fields; in the industrialized as well as developing countries.

NGOs are also a valuable and continuing source of information, opinion and recommendations in fields of mutual interest in which they have special experience and competence. As UNICEF seeks to pay more attention to policies and services related to child development, to children with special problems and to the non-material conditions of the young, issue-oriented and theme-based collaboration is increased; new coalitions of NGOs are formed; new ways of cooperation are developed.

It is, I believe, generally agreed that a development strategy for direct assault on poverty can work only if the disadvantaged segments of population (and under-served areas) are disaggregated for discriminatory, priority attention. I believe that voluntary organizations which operate at the local level are eminently suited to help in this task of identifying people and children as *subjects* of development. Many of them have the flexibility and freedom to respond to neglected problems. They can play an important role in policy formation, by presenting and interpreting needs, and they can monitor action to meet these needs. They can encourage local

participation and enlist local support, especially resources, for development programmes.

UNICEF is of the view that NGOs have a rather unique functional capacity to bridge the traditional gap between the power of government and the potential of people. To the extent that these are joined, development becomes easier. And this is a matter of establishing and continuing communication, contact and trust between the government and the community. NGOs have gone beyond providing this critical link—to organizing social service systems where none existed. Their role becomes important in motivating community interest in basic services. Through innovative projects and determined experiments, they can demonstrate what might later be undertaken on a broader scale with government support. Time does not permit me to dilate on ways voluntary groups can make (and have made) a pioneering difference to non-formal learning; health care; nutrition; family planning; family self-reliance; women's activities; water supply and sanitation; and emergency relief; but some of us present here can testify to the goodness of many of them on the strength of their work in India and elsewhere: I am not suggesting that a group becomes good merely because it is voluntary. But I think that voluntary work does help in the current search for new forms of social life which is what development is about.

It is useful to establish a well-understood system of criteria to promote citizen participation in development. Here again UNICEF has some experience. While our programme cooperation can be extended only on the basis of a government request and for programmes for which the government accepts responsibility, NGOs themselves are, in many instances, designated by governments to carry part of the operations. And the services they provide thus receive a measure of support from UNICEF. Any non-governmental organization which has consultative status with the UN Economic and Social Council or with any specialized agencies, is eligible, upon request, for consultative status with UNICEF. NGOs having consultative status can be present in the UNICEF Board sessions at which they have an opportunity to make their views known. This apart, there is a NGO Committee on UNICEF which promotes a two-way exchange of information and experience between UNICEF and NGOs at national and international levels to encourage consultation and cooperation among NGOs and UNICEF;

and to provide a forum for discussing UNICEF policies and programmes. We believe that this experience is a step, however small, towards a democratic theory (and practice) of development.

The rather mixed development experience of more than two decades should help us in deriving some operational guidance in the field of development assistance :

—There has to be a shift in the *content* of assistance *from* capital intensity *to* relevance to life and living—with predominant emphasis on awareness building, innovation, training, self-monitoring and self-evaluation.

—This must be accompanied by a change in the *distributive pattern* of assistance, leading to greater concentration in area-specific and people-specific assault on backwardness and poverty.

—There has also to be a change in the *character* of programming from centralized, vertical, sectoral activities (however good they may be) to decentralized designs and delivery mechanisms.

—Greater *awareness* on the part of the poor needs to be matched by a stronger spirit of *sharing* by the non-poor. While more value has to be derived (for the people) from every dollar that is spent, there has to be an increase in the quantum of resources available by their transfer internationally *and* within the country.

—And lastly, in keeping with the agreed priority for daveloping the human resource, effort must focus on the young child. Practically, this means strengthening the hands of the mother in village or slum.

Certain policy implications—or imperatives if you will—flow from this perspective. Indeed these are increasingly reflected in the development designs accepted by several governments :

—First, unless the development process is decentralized (in

operational terms) it will not be easy to restore to people their right to be at the centre of it.

—Second, (and I quote from *The State of the World's Children*, recently published by UNICEF) "Organized communities and trained para-professional development workers, backed by government services and international assistance, could bring basic education, primary health care, clean water and safe sanitation, to the vast majority of poor countries in the developing world." As the report argues, it is not the *possibility* of this kind of progress that is now in question; it is its *priority* at the policy, level.

—*Third*, There needs to be political determination to do this.

The concept of converging development is nothing new. But, broadly speaking, we are yet to translate it into live links between various basic services on the one hand and other development aims like employment, productivity and modernization on the other. Nor are the common social services brought together at the stage of their delivery to individuals and families. We have to learn new lessons from the adverse effects of uneven and fragmented development in the political, economic and socio-cultural sectors.

Having mentioned the need for converging the directions and sectors of development, let me point to the equal urgency in bringing together the means of development. Our experience in UNICEF has been that success comes when resources, services and agencies coalesce within a community towards a common purpose and priority. I would consider the human agency as the most crucial.

Within a country, the operational responsibility needs to be clearly shared (without being diffused) between different levels and different groups. On the one hand, intermediate and local levels (state, district and block) have to be trusted with powers coterminous with responsibility. On the other hand, the multiplicity of interest groups has to be drawn into direct and active involvement in development tasks. Increasingly, they want to be so involved, especially in social and human development—for reasons of humanity and enlightened long-term self-interest. And

there are such different dimensions to social change as to leave room for all of them—in organization, management, communication, transfer of resources, technical assistance, provision of supply, lobbying for legislation, support for litigation. There are professional, cultural, religious, business and academic groups who have the competence, inclination and influence to participate. There are youth clubs, women's organizations, cooperatives, trade unions eager to fulfil themselves through social work and service. There is, as you are aware, no dearth of development themes and areas of action for them to get fruitfully involved in as soon as they are ready. For example:

—Literacy of girls and mothers;

—Attack on anaemia in growing children, pregnant and lactating mothers, industrial and other workers. The feasibility of this through the use of iron fortified common salt has been established.

—Control of goitre, (which affects 40 million Indians), by using iodized salt (or other forms of iodine).

—Laying the nutritional foundations of new generations by protecting and promoting the traditional (but threatened) practice of breastfeeding, complemented by appropriate and timely weaning practices.

—Relevant education in support of better health, hygiene, and environment.

—Spreading awareness and changing behaviour by two-way communication through every possible channel.

I have mentioned a few illustrative possibilities but the scope for meaningful NGO participation is virtually unlimited.

The constituencies of voluntary agencies are neither congruent nor in conflict. Intelligently enlisted, they can quicken the pace of development, and incidentally, effect some saving of public money at a time of financial stringency.

The field of socio-economic development is a mosaic of interests, attitudes and ideas. We must have the imagination and patience to tap the richness of its variety to further the aims of development. One way to do this in the context of external assistance is to coordinate (and thereby enhance the impact of) the international commitment. As each agency operates in relation to its own criteria for assistance and is accountable to its own source of support, dovetailing the financial, intellectual and technical resources and efforts for optimum use may not be achieved spontaneously. But I believe this is possible, once the design and direction of development are clearly outlined for the specific purpose of establishing a viable, partnership in development—that could lead to genuine group effort and joint programmes.

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PARTICIPATION IN A PLURAL SOCIETY

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the Jaycees Meeting
Jaipur, 21 January 1983

I am glad to be with you this afternoon for several reasons. The memories of my personal association with the Junior Chamber is one. The generally happy experience of UNICEF partnership with Jaycees is another. The prospect of working for a common cause in times that clearly call for prompt and purposeful cooperation is the third. I am, of course, thankful to you for asking me to spend some time in your company. And I shall try to share with you some of my concerns as the UNICEF Regional Director for South Central Asia and as an individual interested in understanding and responding to what happens around me.

I would like to bring to your attention some facts, as uptodate as I could have them. These are not the best of times, especially for economic reasons which I need not go into in any detail for an alert audience like you. But the climate of economic stringency, of scarce monetary resources for providing the people—and especially the young—with the basic services, devolves a new responsibility on all of us. We have to rethink the priorities of

public and private spending, we have to reconsider and reshape the aims of what passes for "development."

This last year, more than 40,000 young children have died the world over from malnutrition and infection. And for everyone who has died, six now live on in hunger and ill-health. You may look around but not see a child dying; and even a malnourished child may not come into your view, unless you search for one. Yet we have it on reliable estimate that an invisible malnutrition touches the lives of nearly one quarter of the developing world's young children. It steals their energy, restrains their growth, lowers their resistance.

In India (if we go by official statistics), some 118 million children live below what is called the poverty line, about 19 million of them in urban areas. These are the very children whose families are hit the hardest by the general worsening of the economic situation; by the pressure of growing numbers on the family, neighbourhood and nation; by the environmental degradation that puts beyond their reach their rudimentary right to pure air, clean water and cultivable soil. These are the children who need (and often go without) basic services related to health, nutrition, education, drinking water and a safe environment. Their families struggle to survive in dignity but are mostly denied the non-material conditions for their development: the opportunity for self-reliance, self-determination, participation, security, identity, and freedom.

This is the background in which we have to fashion anew and in each national context, the design of development. There has been a great deal of thinking, introspection, experimentation and interaction in many parts of the world (conspicuously including India) in this effort. A measure of consensus can be noticed in this process of analysis and action. And this consensus cuts across geographical and, I think, ideological dimensions. Before I come to the role that an organization like Jaycees can play in this transition, let me state some of the elements of this growing body of opinion :

—The highest priority of development is to meet the basic needs (material and non-material) of people.

—Human and social development is no less important than economic progress. Unless the two go together, basic human needs of all members of the community may never be met.

—Once development acquires a "*human*" focus, it is only logical than the paramount concern should be development from the earliest stage of life.

—Development of the child becomes possible only by strengthening the capacity of the mother, the family and the community (in that order) to attend to this task.

One of the ways—indeed the most important one—UNICEF is trying to promote these aims, is what we call "the basic services strategy." This is a strategic outcome of the varied experience of UNICEF over three decades and in different political systems. It is a concept and an approach that works. It has had the approval of the UN General Assembly in 1976. I would like to brief you on its more salient points.

The basic needs of children are known—safe water, nutritious food, primary health care, clean environment, basic education. These in turn need maternal as well as child care, local production, storage and consumption of more and better quality foods, education of the mother, simple technologies to lighten her daily tasks, and so on. It is our understanding that services of this kind for a community cannot be generated from outside on a viable basis. They can be established and maintained durably and on the required scale only if the community wills to have and works to keep going, these mutually supportive services.

This means that the community for whom the services are meant, is involved from the outset in identifying its needs, deciding priorities, planning the sequence of steps, selecting the community workers, and generally controlling, in a democratic way, the range of activities. A good beginning with a specific programme can develop into activity covering the spectrum of essential needs. The productive use of local human and material resources can keep recurrent costs down to a level the community can afford. In such a scheme of things, the role of government as well as non-government agencies is to assist in meeting the

capital costs and in providing training, and technical and logistical backing. Consistent with this overall strategy and within the framework of national policies as well as the limits of its own resources, UNICEF assumes this supportive responsibility in India, as in 111 *other* countries presently.

This is the development scheme and strategy against which I would commend a few lines of necessary (and I hope possible) action, for your consideration :

—I mentioned infant malnutrition. There is no better way of combating it than by protecting and promoting the natural, traditional practice of breastfeeding infants for as long as possible. This practice is under threat worldwide. It has declined in many countries, especially in urban areas. The demand for the socalled substitutes for the mother's milk is as artificial as the feed itself. A food as good for the infant as breastmilk is yet to be invented. The hollowness of claims to the contrary have been widely exposed. We would be glad to send you relevant literature on the subject, should you be interested in mounting a public information campaign in Jaipur starting with people in the slums.

—This campaign to be fully successful, needs to be complemented by a concurrent promotion of proper infant feeding practices—the timely introduction of the right kind of home-prepared weaning foods, made from simple, locally available, low-cost cereals, legumes and vegetables. Purely commercial interests are unlikely to be interested in inexpensive alternatives such as these, but socially-conscious groups such as yours can well be.

—Global estimates speak of 1400 million episodes of child diarrhoea during 1980—leading to 5 million child deaths from this single cause. A good number of these episodes and deaths occur in South Asia.

—Diarrhoea can, of course, be prevented by ensuring safe water, proper sanitation and hygiene education. But this will obviously take time. And something needs to be done

urgently and effectively to stop the unnecessary and massive child deaths.

—The answer is known to us, but not to the mother in slum or village. All that is needed to prevent death from diarrhoeal dehydration is *not* to deny fluid and food to the stricken child. At the present level of understanding, the mother denies both even as she waits for diarrhoea to stop. Unaware of cause and effect, she takes it as an intervention of fate should the child die.

—The answer to preventing child death from diarrhoea is creating the awareness of the right response. And, modern science tells us that the response is incredibly simple. A solution in water of sugar and salt in reasonably correct proportions can save the child. This can be made in the home. Recent research also vindicates the traditional (but forgotten) practice of giving children with diarrhoea rice-water or similar fluids with some starch content. As you see, science assures us that the problem is hardly medical. It is social and behavioural. The answer is better understanding through appropriate communication. The problem lends itself, I believe, to a strategic intervention by a dynamic group like Jaycees.

There are as many areas as you would care to explore, to help the deprived child. Examples :

—An attack on anaemia, which is widespread among children and mothers in this part of the world. This is possible by promoting the production, distribution and consumption of iron-fortified common salt. It is feasible and not costly.

—Forty million Indians are reported to be affected by goitre from iodine deficiency. Most of them are not even aware of this condition. More may in fact be suffering, as further investigative research may show. The answer, once again, is not beyond available means : use of iodized common salt instead of ordinary salt. Experience shows that this is mainly a matter of efficient management.

—There is a whole range of simple interventions possible to prevent and to limit childhood disabilities which defy similar action in adulthood. Universal immunization is one such. Technologically and financially, it is feasible. Yet it is not happening even where facilities exist—mainly due to lack of social consciousness. The distribution of Vitamin A capsules to children is possible; cultivating the habit of eating green leafy vegetables is even easier; and education for health and hygiene is essential, as a preventive of much of visual impairment in childhood.

UNICEF stands in readiness to respond with information and advice to any interest you may take in alleviating the condition of children from materially poor families and in promoting their development in one or another of the fields I have mentioned, or in several allied areas for action. There are several avenues by which you can extend your collaboration—for example, one or more of the numerous projects of Integrated Child Development Services (ICDS) of the Government of which UNICEF is a partner.

Before I conclude I would like to stress the importance, in a plural society, of participation in development by non-government organizations like Jaycees. You can provide the link (often missing) between the government and people. Even if you are not in a position to organize relevant social service systems, you can support attempts in this direction. You can coordinate your effort with that of other voluntary agencies in the field of development. Finally, a combination of your managerial capability and social consciousness can make a difference to the quality and outcome of any social service that you may decide to start or support.

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A LEAD ROLE FOR VILLAGE WOMEN

Statement by David P Haxton, UNICEF Regional Director for South Central Asia at the Rajasthan Workshop on Development of Women and Children in Rural Areas (DWCRA) Jaipur, 21 January 1983

I am happy to be present and participating in this Workshop which marks the beginning—in Rajasthan —of a fresh effort at development of, for and by rural women from materially poor families.

Your State is known for its hardy working women who think nothing of venturing far out of their villages to fend for their families. It is a little sad, therefore, that they live to see many of their children die before completing the first year. I refer to the reportedly high infant mortality rate among Rajasthan's migrant communities of construction labour. We have here one dimension of what "development of women and children" is about in a context of rural poverty.

The UNICEF concern for protecting children naturally leads us to ways of assisting mothers and prospective mothers. So we have been cooperating in India, as in other countries, towards meeting the needs of both, in health care, nutrition, learning,

skills training and, more recently, activities related to increasing family income. Experience—particularly in Sri Lanka and Kerala—suggests that the relatively high proportion of literate women is an important factor in their relatively low infant mortality.

Improving the situation of women requires "programmes" for women as well as a review of existing common services in health, nutrition, education and social welfare to take into account the distinctive needs of women. Generally speaking, neither has been happening in most developing countries. This is the background in which the global UNICEF policy focuses on cooperation in five allied areas :

—more information on the situation of women as a basis for preparing relevant and viable programmes for them ;

—advocacy on behalf of women (and of course their children) from poor communities, with sensitivity to the particular cultural, political and social environment of their lives ;

—women's income-generating activities which lead to a reduction in their dependency ;

—increasing participation of women in the life of the community ; and finally;

—feedback on, and evaluation of, the results achieved.

This approach substantially coincides with the perception of the Government of India, derived from 30 years of rather mixed experience with community development. UNICEF was particularly pleased that the interests of women began to be formally reflected in the five-year development plans. This happened about much the same time that the International Development Strategy for the 1980s addressed itself to the tasks of social and human development as an objective no less important than economic progress. But plans and strategies (however sound they may be) are only as good as they work. Our task today is to see that they do.

Let us be clear about the full significance of the new emphasis on women's development. Women—illiterate women from marginalized families —cannot be limited in their roles to motherhood and to the household. The part they play as mothers and wives ought not to eclipse their equally crucial role as economic providers, as citizens and as individuals in their own right. I am not suggesting that this view on women is novel to India or Rajasthan. We have to give shape to it in reality. And UNICEF is hopeful that the "development programme for women and children in rural areas" is an answer to this need—however cautious and modest it may be to start with.

There are several factors that stand in the way of women's development in a rural setting. These arise mostly from habit, custom and ignorance. For instance, most of the training of people (in the field of agriculture for example) is traditionally dedicated to men while much of the work done on farms in the developing countries is by women. Women are more important to children than men, yet their own opportunities to learn are considered unimportant relative to those of men.

A recent study of rural communities in a neighbouring country throws interesting light on the negiect of female education. It is neither the cost of education nor the conservatism of the parents that is the primary cause of the lower percentage of school enrolment of girls. Rather it is the family's dependence on girls' labour at home and in the fields that is the primary reason for keeping them out of scool. An obvious answer is to find gainful work, preferably in the home itself for the female adult.

Again, in rural communities where fewer restrictions have been imposed on women by tradition and culture, there is greater willingness to educate girls. As we can afford to lose no further time, we have to go beyond educating girls to bring functional literacy to the female adult. And this is an important component of the programme you are launching. Attempts have been made to promote learning by girls and women, but results have not been as good as they should have been. We must tackle the reasons for this—in the present programme.

Aims do not (and need not) change, but methods and approaches can. And UNICEF is keen that they do.

Let me give you a couple of illustrations about new methods of tackling old problems :

Who are the people (women in this case) in need of help ? Wisely, the programme defines them—as the poorest of the poor and limits its ambition to a modest number of families. But how are these families to be identified ? One way is to conduct surveys of family income and other indicators. Another is to leave the task to the perception of the nearest government official or existing institutions of local self-government. It is known that these processes take time or are not entirely reliable. Can the local community (where everybody knows everybody else) do the selection themselves and in the open ? Can they go farther and designate, and oversee, the community organizer as well ? I think your programme leaves room for both. Which is fine, but there may be a problem that we, who have assembled here, are not used to such simple elementary procedures. So the challenge the programme poses lies not in its concept nor in the people but in the capacity of its managers.

Once the women are identified for the programme, how are their needs to be known ?—before they can be met. Luckily the programme does not lay down any rigidly uniform procedure for the whole country for this process of understanding. For, individual needs and local resources vary with place and time. There needs to be a method and a mechanism to listen to rural women as well as to communicate with them. They are very intelligent, but generally they are not used to confiding in government officials, bank functionaries or even newspapermen. They are ill at ease even when they are approached through existing women's groups that are controlled by the local elite. Which is one reason why the poorest of the poor have themselves to come together in small groups and discuss their needs and problems and answers first among themselves and then, with those who appear to be helpful.

So, those who are responsible for the programme have to cultivate empathy for the people they are expected to serve, before they achieve communication with them. The civil service, in this country or elsewhere, is no longer confined in its role to maintaining law and order but is called upon to shoulder development

administration, prominently including social and human development. The present phase is one of transition and adjustment by public servants in preparation for social change. This is the context in which UNICEF advocates the increasing association of local voluntary organizations in socio-economic programmes. Some of them have a record of useful social work and have established an identity with poor rural families. With needed support from government, they should be able to help promote the aims of the programme. This possibility remains open and should, I submit, be fully utilized.

In discussing programmes such as the one this Workshop is seized of, the question of confrontation between conflicting interests in society naturally comes up. The aims of the programme admit of no compromise ; but they need not lead to a conflict situation—if persistent persuasion by government combines with group pressure from the marginalised community. If this happens, vested interests, in their long-term self-interest, are likely to cooperate at least in token terms and give up their opposition. It is a function of the programme management to make this happen.

There is a familiar, parallel fear about financial resources being perennially insufficient to fulfil programme aims. This has to be consciously overcome. Experience shows that it can be. For it is often that budgeted funds do not get utilized in time. More importantly, there is a marked tendency to overlook the availability and relevance of non-monetary resources. These come in many forms :

—appropriate technology to lighten labour ;

—better ways of managing existing resources ;

—increasing use of local low-cost sources of nutritive food for infants during the weaning phase as well as for normal adult consumption ;

—breastfeeding of infants for as long as possible ; this costs nothing and is within the physical capacity of mothers from poor families ;

—preventive health care which is simple enough for illiterate women to learn but saves money, time and trouble for the family and the government ;

—safe drinking water and cleaner personal, home and village environment come in the same category of conserving health and saving expense in money and energy ;

—community development of fuel lots in the neighbourhood so that the daily search for, and cost of, cooking fuel are cut down ;

—pre-school and child-care centres release the mother for productive, part-time employment while assisting in the child's own development and preparation for life ;

—finally, child-spacing and family planning help to conserve the resources available to a family and optimise their use.

This indeed is the foundation on which your programme is based. None of these measures calls for much investment. Some need no financial outlay. But all of them have a significant money-saving potential. It is on this foundation that income-generating activities have to be built-up. It is one structure of which every part has to be sound. What is needed is the interest and the imagination to improvise and investigate. This is a matter not only of knowledge and skills, but also of attitudes and aims and ultimately of values and principles, of a new and humane culture. I suggest you set your sights on nothing less—as a moral investment in your important venture.

I come back to the need to orientate ourselves before we become instruments of social change. To the extent this need was neglected, past attempts at social development did not succeed. The roles of government, voluntary agencies and UNICEF have to combine to support the lead role of rural women, in this programme.

There can be no imposition—even of ideas—on people. Indeed people cannot be developed—they develop themselves. The parts we play as organizers, trainers, administrators, communicators

and service promoters have to be understood as ancillary and supportive to the effort of village women to take full charge of their own lives. It is not that today they are not participating in economic and social life around them. But we are not ready to recognize their part. It is not that rural mothers do not care for their children. But we do not see the handicaps with which they try. We do not seem to accept willingly that women provide the element of stability and continuity to the basic social unit that is the family—in the midst of the socio-economic unrest of our times. The hope lies in rural women transcending their travails through :

—the solidarity of group effort;

—the self-reliance that comes from awareness and confidence, and;

—the healthy autonomy that income-earning capacity generates.

For our part, all programmes assisted by UNICEF are evaluated for their impact on women. We seek to introduce corrective measures or new components on behalf of women, for counteracting negative or neutral trends. We try to enhance returns from the work a woman already does, to abate its burden and drudgery, to increase her access to training and credit ; and that of her product to the market. We encourage formal learning as well as self-learning of women and girls. We seek to promote self-employment in their own homes. We try to protect the child by strengthening the hands of the mother.

This is the perspective in which UNICEF cooperates in the programmes for development of women and children in rural areas. And this is the reason for our keen interest in this workshop and its outcome.

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AGAINST ANAEMIA

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the Meeting of International Nutritional Anaemia Consultative Group
New Delhi, 19 April 1983

May I begin by thanking the Director-General of the Indian Council of Medical Research and the International Nutritional Anaemia Consultative Group in giving me this opportunity to say a word on behalf of UNICEF.

From studies made and data available, three basic inferences are possible :

First, of the world's estimated five hundred million anaemic persons, anywhere upto half that number may be living in South Asia. In India alone, around half the number of preschool children and pregnant mothers have been reckoned to suffer from anaemia.

Second, iron deficiency has been established as the most common cause of anaemia in this part of the world, as elsewhere. It has direct and major public health, economic and social consequences. For example, it threatens the life and health of the mother at the time of birth; it limits the weight and viability of the infant; it affects the capacity and will to work.

Obviously iron deficiency anaemia is an inviting field for further research but, we believe, enough is known to feel impelled to move from laboratory to national scale.

Third, the answers are available. Yet they are not so applied as to reverse, or arrest, the anaemic trend. In India, for example, ferrous sulphate-folic acid pills are being supplied by government to some five thousand primary health centres (a service that UNICEF used to support until the mid 1970s). But there seems to be a need to improve the relationship between actual supply and real demand.

The findings of over a year ago, by the National Institute of Nutrition on community use of iron fortified common salt (a study funded in part by UNICEF) point to exciting new possibilities of scaling up such operations nationally. There is no insurmountable obstacle in the way: financial, technological or professional. Yet the pace of progress has been slow. How can this technology be applied more widely and rapidly in more countries? Progress, it seems, presents us with a rather disturbing background. And, at this stage, and in this forum, UNICEF can do no better than suggest that the considerable weight of INACG be put on the side of the apparently receding priorities for policy and action on behalf of the anaemic half. These priorities, in our view are fairly obvious.

—The public distribution of iron pills (in whatever form) will have to expand and effectively reach all pregnant mothers and young children. We believe the infrastructure is available in most places. The cost is not prohibitive. What is weak is the recognition at the policy level that this needs to be done; and at the operational level that this must be done.

—Iron fortification of common salt for general consumption has to be taken up as a public health measure on a national scale. Continuous supply of fortified salt needs to be so organized that the programme does not suffer from fragmented responsibility or bureaucratic concentration. The process should be recognized as simple enough in technology and management for the consuming communities to be associated with it.

—Simultaneous with the effort to restore iron to people, established and alternate channels have to be utilized for deworming and other anti-anaemia operations, on a continuing basis.

—Employers in factories and plantations, offices and other establishments have to be awakened through regular information campaigns, about stepping up productivity, perhaps dramatically by giving employees access to iron pills. Logically and easily the coverage should extend to the workers' families.

—Dietary education and motivation should be geared appropriately for vegetarian populations, with particular attention to factors inhibiting the absorption of iron.

—The results of research must be deliberately used to protect sound infant feeding practices against commercially motivated arguments. For example, the mother's milk is said to have low iron content, but contrarily, the bio-availability of iron to the breast-fed child is adequate during the first year of life.

The anti-anaemia role of health ministries is evident. Equally, it is clear that much of the effort goes beyond the conventional health sector—pointing to the emerging need to see this element of social development as a matter of policy priority and to see it as part of a combined thrust.

UNICEF stands ready to co-operate with governments, sister agencies, and non-government organizations to move forward on the anti-anaemia front.

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WORKING FOR CHILDREN : THE UNICEF ROLE

Public Address by David P Haxton
UNICEF Regional Director for South Central Asia
Bombay, 2 June 1983

It is a legitimate question to ask of UNICEF what it can do for the well-being of children in a country where so many of them cry for attention? We ask this of ourselves almost constantly. And I must say that our answer has evolved with time, our understanding and our experience. In this sense, the role of UNICEF in India has had a dynamic focus under a constant purpose. This evening I would like to present to you a picture of our changing response to a social problem among the toughest anywhere.

Conventionally, UNICEF has three broad functions :

—To be of assistance to children during emergencies like natural disasters and war;

—To promote development of children in depressed sections of society by co-operating with national governments; and

—To advocate appropriate policies and measures for development of children.

In a situation where endemic poverty and disease of one kind or another continuously feed on each other, it is difficult to see the three functions apart from one another. And a deeper analysis is necessary to understand the nature and thrust of the UNICEF role.

Firstly, let me touch on our basic approach to the task of development. We have learned from experience that it is not enough, for viable result, to set the goal of development as growth or well-being. The goals have simultaneously to be growth, well-being, equity and participation. The development of children in human, economic and social terms cannot be assured in a narrow spectrum of aims. If this is accepted, the strategy must be one of response to the needs of people, particularly to those of their children. Even where this is accepted in theory it is seldom put into practice due to constraints imposed by concepts, attitudes and institutions. How does a government respond on a national scale to the needs of numerous communities who are without access to channels of communication? How does a bureaucracy, used to telling people what is the good for them, adapt itself in thinking and structure to listen to those whom they are expected to serve? If development is defined as a total concept (and nothing less would do when it comes to development for children), questions such as these crop up insistently And purely technocratic answers may not satisfy.

We of UNICEF seek to mediate the desired process of development by assisting in building the capacity of people to analyse and understand their needs, to respond to them by themselves, or to demand the needed services of public sources. The emphasis is therefore strongly on training, orienting, communication, planning, inter-sectoral co-ordination and nurturing of institutions rooted in and functioning at the level of the community.

In determining the scope of UNICEF support to the community for building up its own capacity, we seek to apply a simple criterion. The intended capacity must be related to a basic service for children such as primary health care, primary or preschool education, basic nutrition (including that of the pregnant or nursing mother), safe drinking water and environmental sanitation. Equally we explore and promote the possibility of ensuring these basic services to the same children at the same time. This is

essential because experience shows how pointless education would be without nutrition; or how wasteful health care would be without environmental hygiene.

From this perch of understanding UNICEF has evolved what is the central idea behind our programmes, namely the Basic Services Strategy. Ever since the General Assembly endorsed it seven years ago, we have been advocating it and we also hear from time to time about one country or another accepting it in practice. But I am afraid its practice has not gone sufficiently ahead. Were it advanced in fact as well as in concept, we would surely not be reading the kind of statistics we have on child mortality, morbidity and under development. We try therefore, to hasten the process of building the Basic Services Approach progressively into every programme we decide to support. We have to convince, persuade, prompt, encourage and sustain *others* to adopt and work that strategy, the main implications of which I would like to reiterate :

—first, active involvement to the maximum possibility of men and women of the community in planning, establishing and maintaining the services;

—-second, the use of trained local men and women, part or full time, chosen by the community to work these;

—third, the use of the needed number of auxiliary staff with substantial responsibilities together with the local workers, would make it possible for professionally qualified personnel to concentrate on more specialized roles as trainers, facilitators and advisers;

—fourth, the application of technology appropriate to the local social, cultural and economic conditions; and

—fifth, contributions in cash, kind, labour and other services from the community to start and sustain basic services.

Naturally, our aim is to invest our programmes increasingly with these strategic ingredients. And the only way we can try to do this is to influence people through persuasion, by the force of fact and argument. Thus another dimension of our role emerges—as

the children's advocate. We advocate policies and programmes appropriate to each national and socio-cultural context. We maintain a voice in domestic as well as international forums, as well as through public media, as the lead agency for children in the UN system.

At this point, I would like to clarify that UNICEF does not plan or execute development programmes all by itself. Rather we assist the government and through it other public or private agencies. Consistent with our global policies we try to influence national programmes so that they steadily reflect UNICEF policies. Whether we succeed in this is the test of our advocacy.

As you will have noticed the State of the World's Children 1982-83 puts the accent on half a dozen themes—not as an answer to the poverty in which children are born and brought up, but as a means of seeing children through despite poverty. None of these programme themes is new but all of them are absolutely and urgently called for, for example, in India.

On a rough estimate anywhere upto two million young children die in India as a consequence of diarrhoeal infection. Many more suffer but survive, the more malnourished for each episode. Each increase in malnutrition increases the risk of another infection. The real threat to the life and well-being of children is not diarrhoea but the attendant dehydration. The answer to this is with the mother in the home—a mixture of sugar and salt in water in a reasonably right proportion. If the mother in the village or slum is made aware of this answer, child deaths will be far fewer and child health will be much better.

Hundreds of thousands of young children die in India from common childhood diseases like measles, diphtheria, tetanus, whooping cough, poliomyelitis and tuberculosis. By and large vaccines are available but vaccination does not usually take place. Here again, the answer is social awareness and social demand for preventive health services.

In poor as well as not so poor families, it frequently happens that child malnutrition and ill-health increases without anyone noticing it. Some way to monitor weight or height or arm

circumference is essential if misfortunes are not to come by surprise. Keeping a watch would help to preserve normal nutritional status, for intervention can be made as soon as growth falters. And intervention is possible once again at the home and within the family's needs—given the knowledge that it can be done.

Infant nutrition is in a state of crisis—for no reason at all. For, there is no shortage of infant food, at any rate for the first few months of the child's life. Yet more and more mothers, well-to-do and poor, in town and even village, give up breast-feeding their babies. They opt for the expensive and inferior alternative of artificial feeding—opening the way to malnutrition as well as infection. Regulating irresponsible sale of milk powder is one aspect of this problem. Even more important is the education of the mother for restoring the baby to the breast.

It is the perception of UNICEF that attention to these four simple practices, reinforced by public policies of food supplementation and family planning, can make a difference to the present, unacceptable state of the world's, and India's, children.

In this conviction we are building, as fast as feasible, the chosen themes into all our programmes and activities which we are supporting wholly or in part. For example, the idea of improved infant feeding practices (which include not only breast-feeding but the timely introduction of the weaning food) is inserted wherever possible—verbally, in writing, in curricula, with cash assistance, with supply assistance, with persuasive advocacy into each element of all things we support. The same approach applies to our other priorities for children :

—early learning associated with health, environment and improved quality of life;

—effective promotion of primary health care;

—improved management of infant diarrhoea ;

—prevention of anaemia, goitre, blindness and other disabilities.

The scope of development is obviously and vastly more in children than for adults. Development may be seen as a process of breaking through the envelope of poverty. But poverty rarely exists alone. Disease, disability, deficiency, ignorance are its usual accompaniments. Before development can start these have to be tamed; or else time and resources will be pre-empted by the battle against these adversities, rather than be available for the positive purpose of development. In this perception, prevention becomes paramount, as a concept and as a practical priority. Which means that UNICEF would like to apply its modest resources on preventing malnutrition rather than on treating it. We would rather promote the use of iron-fortified salt against anaemia and iodinated salt against goitre, than wait till more children and adults become anaemic or goitrous. We would rather encourage nutrition to the pregnant mother than support the establishment of maternal clinics; promote breast-feeding and proper weaning practices than support medical facilities for young children. When current suffering is heavy, prevention is not the sole answer, but without it nothing would be an answer.

You will have noticed that the main means at our disposal for furthering the aims on behalf of children is, in one word, *communication*. This is a programme tool of which we seek to make full use. We seek allies by using this tool, not only in government agencies, but also in non-government organizations, trade unions, employers' groups, religious bodies, youth clubs, women's groups, co-operatives and so on. And we are increasingly interested in making use of each of the public media to reach messages to the people. This is one way we hope to enlarge the effective use of our modest resources on behalf of the 270 million children of India, about half of whom are at or below the line of poverty.

There is a dimension of UNICEF programming which I have not mentioned yet. We are increasingly concerned in evaluating the outcome of development not merely in terms of the money spent or even in terms of the quantitative targets achieved, but in terms of quality of child life. This is a long haul, but a needed one.

From what I have said it would be clear that the approach sustaining the UNICEF effort has necessarily to be decentralized, cross-sectoral and inter-disciplinary. Child life cannot be treated

in compartments. Nor can the functional aspects of development like policy-making, funding, management and technology, be dealt with in fragments. In this perspective, certain programming patterns have emerged and I would mention two typical examples: integrated services for child development ; and area specific and people specific development for children. Both are currently expanding with government support and gradually increasing people's participation. The UNICEF contribution to this process is not so much its funding or its expertise, but an extra degree of concern that raises the priority for children in the design of social development—priority in time, for resources, of public policy.

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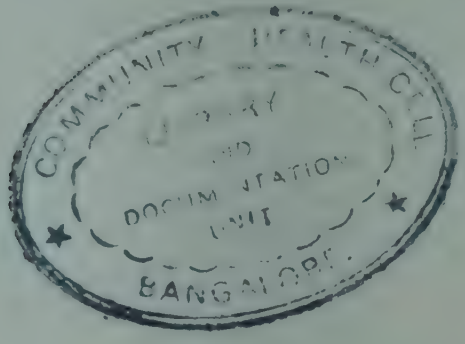

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CHILD CARE IN INSTITUTIONS

Statement by Alexander C. Tosh, Officer-in-Charge
UNICEF Regional Office for South Central Asia
at the Workshop on Training
for Functionaries of Child Care Institutions
Madras, 28 June-1 July 1983

The United Nations Children's Fund has a mandate from the General Assembly of the United Nations to be the advocate for children. It is in the role of advocate that I must address you today since UNICEF's experience in addressing the problems of homeless children is limited. Our policies are not yet well-defined and our present involvement exploratory. However, we can say that our advocacy and action in 112 countries around the world are based on a firm belief in every child's right to opportunities for healthy normal development in freedom and dignity ; a name and nationality ; adequate nutrition, housing, recreation and medical services ; love, understanding and an atmosphere of affection and security in the care and responsibility of their parents wherever possible ; education and equal opportunity to realize his or her full potential ; and protection against neglect, cruelty, exploitation and discrimination. These rights are the due of every child whether born in the security and affection of a good home or in the most distressing circumstances.

In keeping with this mandate and its belief in the rights of the child, UNICEF enunciates policies on a number of issues and these policies determine the way in which its concerns are translated into action. UNICEF's primary concern is with the survival, protection, care and preparation of the child. In agreement with Governments, and based on local needs and initiatives, UNICEF reflects its concerns through response at various levels. At the first level UNICEF provides direct inputs which benefit mothers and children. This was the early and traditional role of UNICEF when it first addressed the problems of a homeless generation of children in Europe at the end of World War II. To a lesser extent that role is still with us today.

At the second level of response, and in support of the principle that the ultimate objective of all assistance is to set in motion and sustain the capability of communities, community workers, and programme implementors to undertake responsibility for development initiatives and improve the quality of services for children, UNICEF co-operates in the training of personnel at all levels.

At the third level of response, UNICEF is the advocate for children. Among the public, governments and like-minded organizations, the UNICEF role in advocacy is to point to the rights and needs of children, to draw attention to them and propose solutions to problems which afflict mothers and children.

And finally, UNICEF assists in research and development in support of realistic planning, effective monitoring and assessment and judicious evaluation.

How do these five statements relate to the problem of child destitution and abandonment ?

I am informed that in 1969, an estimated 1.05 million children in India were considered to be destitute. With the subsequent increase in life expectancy, the number of orphaned children is estimated to be on the decline. Paradoxically (and even though reliable statistics in the magnitude of the problem are not available) the total number of destitute children is considered to be on the increase due to abandonment and break-up of family systems.

For the increasing numbers of these abandoned and destitute children, providing an environment that is conducive to their survival, protection, care and preparation assumes priority. It implies that children in institutional care should receive quality services that cater to their *total* needs for development—physical, cognitive, social, emotional and moral.

Generally speaking, abandoned infants enter life with a bad pre-natal history and tremendous odds against their survival. If unwanted, they may have withstood unsuccessful attempts at a termination of their lives *in utero*. Their mothers may have received little health and nutrition care during the crucial pre-natal months and may be dangerously underweight. Births may in all probability have occured in conditions of secrecy and lack of adequate care. In such situations, the fragility of the neonate and infants is accentuated and their continued survival further threatened by malnutrition, dehydration due to diarrhoea, and by infectious and communicable diseases.

The first and urgent response of an institution in these circumstances is to ensure survival. Immediate intervention is needed. Fortunately, we have at our disposal the means to effect it: breast-feeding as early and for as long as possible ; supplementary feeding from 4-6 months of age to ensure growth ; oral rehydration therapy to prevent dehydration when diarrhoea strikes ; clean and hygienic surroundings ; management of sickness and referral when necessary. All of these are low cost and cost-effective interventions at the disposal of every institution.

Once the child's survival is ensured, his or her care and protection demands attention. Here, immunization against the six common diseases—tuberculosis, poliomyelitis, diphtheria, whooping cough, tetanus and measles—which account for some five million children is necessary. That should adequately protect the child from morbidity, disability or worse physical onslaughts. But, in addition, adequate mothering by the main care-takers, hygienic child care practices, growth monitoring and early detection and intervention for impairments and disabilities need to be provided. Again, none of these demands heavy financial inputs. All are available if the knowledge and will are present.

I understand that some institutions and agencies have demonstrated considerable success. One agency, I believe, has set up a system of wet nursing involving women from the community and the house mothers themselves and it has inevitably resulted in a dramatic improvement in the infants. Others rely on foster care of infants to ensure that they are not deprived of the mothering and the parental warmth so crucial for early development. In some homes all children are carefully immunized and others have fine records in sanitation and environmental health.

While protecting and caring for children it is necessary to prepare them also for adulthood. This is an even more complex matter. Early stimulation, opportunities for optimum physical growth and development, the inculcation of self-help skills and appropriate attitudes and values; opportunities for learning; recreation; an atmosphere for the development of emotional and personal maturity; and pre-vocational training and the development of productive skills all constitute necessary conditions for the child's preparation for adulthood.

Care and preparation of the child for adulthood starts from the very moment of birth. The evolution of the child's personality and his or her behaviour as an adult is a function of the nature and quality of the child's experience from infancy. Early stimulation and maternal warmth have as significant an impact (if not greater, as some would say) than later education and vocational training.

The effects of institutionalization on children are now well known and documented. It is acknowledged that other things being equal, care in family situations is infinitely more favourable to children. In cases where institutionalization cannot be avoided, effective methods for providing children with a family atmosphere which provides early stimulation, emotional warmth and effective adult role models for identification become necessary for normal maturation.

And finally, in support of the necessary conditions for survival, protection, care and preparation of children must be ensured the basic amenities of clean water, sanitation and adequate shelter and clothing. As a means of preparing them for their future roles as responsible citizens, they must play an active part in the care

and maintenance of these surroundings. Not all of these services are expensive, but they must be sought after.

Training

It is against the back-drop of the child's primary needs that we must address ourselves to training and capacity building. Each person concerned with the delivery services to children has his or her own specific role to play. House mothers, for instance, need the knowledge and skills to reflect these elements in the day-to-day care and upbringing of children. Even today, in this enlightened gathering can we be sure that everyone present has the knowledge, skills and commitment to put into effect the monitoring of growth, the sequence of childhood immunizations, the insistence on breast-feeding and the rehabilitating process of rehydration in episodes of diarrhoea. Supervisors and organizers of voluntary agencies must support the day-to-day caretakers with the necessary knowledge, conditions and services and their capacity to seek and implement effective strategies. Officials within the Government infrastructure must be supportive partners of NGOs and trainers skilled in identifying and utilizing effective techniques for inculcating the necessary knowledge, skills and attitudes that are the very heart of capacity building.

In conclusion, I would repeat the UNICEF presence here today and our continued involvement and deep interest in the issue that you will address over the next few days is based on our genuine concern for the survival, protection, care and preparation of all children. This is as real for children in institutions or who are homeless as for children in family circumstances. In some of the best institutions, as in the best homes, there are enlightened and informed parents, be they surrogate, who provide love, security and emotional stability. In some institutions there are provided all the basic amenities necessary to support normal child development. In others there is careful monitoring and protection of health and growth. In the very, very happy few there are all of these things. It is important, therefore, that we learn from the examples provided by others, exchange experiences and viewpoints, all the while building our own and others' awareness of the

complexity of the problem, increasingly attracting support and activating the consciousness and the conscience of society.

This meeting will be a significant contribution to all of these.

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A PARTNERSHIP FOR CHILDREN

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the National Conference
of the Indian Academy of Paediatrics
25-28 November 1983

It is for many reasons that I responded with pleasure to the invitation to address this Conference and to participate in its inauguration. The most obvious reason is the vital overlap of our concerns reflected in the fact that, of the 160 or so scientific papers being presented here, around a fourth are of direct relevance to on-going programmes of UNICEF co-operation in India. UNICEF has always had a productive partnership, in a common cause and in many countries, with paediatricians—one of whom presided with distinction over our Executive Board.

There are deep and compulsive social and professional reasons for our coming together at this time. The situation of children in India is unacceptable equally to the people and government of the country; to the paediatricians (who are more involved than any other profession in the healthy development of children); and to UNICEF which is designated by the UN General Assembly as the lead agency for children.

Of the 40,000 of the world's children who die each *day* from easily immunizable diseases, diarrhoeal dehydration and the vicious interplay of infection and malnutrition, around a fourth would be in India. The daily recurrence of this order of human wastage may have nearly numbed our sensitivity. But a little reflection would reveal that this social shame is entirely avoidable.

Neither poverty which submerges upto half the hundred and more million children under six years, nor the rate of population growth which strains the capacity of parents—and governments—to care for children, can fully explain the unusual withering of young lives at the present speed. Rather, the explanation lies in the delay to a linking-up of the insights of science and the resources of society on behalf of these children.

Science holds the key if we decide to use it. It has been established that child health need not lose out to poverty. Instead, it can be secured despite low incomes and become, in time, the most effective bulwark against poverty. For, as child health improves, productivity of the poor should rise ; the need for large families, to insure against child deaths, would diminish ; and the proportion of children to the total population (now nearly 40 per cent) should fall.

In the remaining minutes available to me, I have set for myself the task of persuading you that : the current infant mortality rate of 125 in India can be halved in the next few years—if the paediatricians of India accept this goal as their own, collectively and in the sphere of their individual practice. The people are awaiting such an initiative ; the government is keen on the support of the profession ; UNICEF is ready to extend its utmost co-operation.

I am conscious of the limitations set by time and your commitment to tasks on hand—even as constraints exist on the resources of the government. So I will be careful to suggest only available, feasible and affordable proposals for your acceptance.

Consider for example the need for a special programme against diarrhoeal dehydration from which, every 10 seconds, somewhere in India, a child suffers. As you know, we have *the* answer in *oral rehydration therapy*. ORT is not a second class substitute for

intravenous fluid feeding. It is an uptodate, scientific, effective, safe and practical form of intervention for 95 percent of the cases. The cost involved is negligible, even for the poor. Used promptly it can correct or even prevent dehydration from diarrhoea. But unless it is used, it will remain just a potential and diarrhoea will claim its daily victims in child deaths and malnourishment and faltered growth.

I submit that the appropriate strategy for a national programme of diarrhoea management would broadly imply that :

—*mothers* give the home-made solution to prevent dehydration. For this, a massive education programme is required through all social communication chemels—TV, radio, theatre.....

—*health workers* use ORS packets to correct mild to moderate dehydration; to achieve this production must meet *real* demand, not calculated potential. The packet must be as available as matches or tooth brushes. And

—*health centres and hospitals* provide intravenous therapy to treat severe dehydration.

There is an urgent need to impart this knowledge and skill to the mother so that she gains the confidence to play her crucial role. This is where you, as a doctor, can give a decisive professional lead. You have the knowledge, the prestige and the influence to make the difference to the diarrhoea management programme. Your advice to your patient (directly or through the health worker) on the proper preparation and use of the home fluid, regardless of what other medication may be indicated in addition, will determine the role that ORT will play. Your practice will set the pace. You are the critical leader. With your involvement, ORT will become part of the consciousness of the community, of mothers especially, and the programme will become a national movement against diarrhoeal deaths and malnutrition. But even more than that, we ask you "speak out" in *all* media and promote this primary health care approach. The nation has a right to ask : Will the paediatricians play their part ?

Let us take a look at the global picture of immunization. In a world that has mastered the means of preserving and prolonging life, it is unconscionable that each year five million children in the developing world die, and another five million are disabled, by half a dozen preventable childhood diseases. A good many of these deaths and disabilities occur in India. Measles alone kills more than a quarter of a million children in the country. No statistic can however express what it means to a family to see a child die needlessly this way.

Vaccination is over a hundred years old in India. EPI was launched five years ago. Yet we have little to show by way of effective coverage. And the goal of universal immunization by 1990 remains a challenge. UNICEF believes in (and is working for) this national target. A cluster of measures—organizational, financial, technological, logistical, and productional—is called for, but equally decisive is the leadership to the EPI movement from the medical profession. UNICEF notes with appreciation the initiative taken in this respect by the Indian Academy of Paediatrics and I hope that a consensus will soon be reached on the "immunization schedule" between the government and the Academy. May I also suggest that each of you assume the responsibility for ensuring that total immunization coverage is achieved in a defined geographic area around your place of practice? Given your commitment and guidance, the problems of summoning the supplies and supportive human resources could, I am sure, be solved. A statement was issued by the International Paediatric Association in Manila recently wherein IPA and WHO join forces. For its part, UNICEF dedicates its own modest resources to this aim. We look forward to each of you doing likewise and to collaborating with you in this task.

Another obvious means readily available to bring down infant mortality and childhood illnesses is to restore to the baby its right to mother's milk. A combination of regulatory measures to curb contrary forces and positive measures to enhance public awareness is called for. UNICEF believes the stage for debate is over and the time for action is now. The international code of marketing of breastmilk substitutes would not have been passed without powerful backing from the paediatric profession. It is the same support that can, and will, see the code implemented

at the national level. Indeed, without the momentum that only the medical profession can impart, even a national marketing code might not make a difference. But we need not wait for the national code (even while we shall strive for it.) May I take this opportunity to appeal to you to make it known that you do uphold in your daily practice the specific injunctions of the international code, for example :

—commencement of breast-feeding immediately after birth ;

—Preventing separation of child from mother ;

—frequent on-demand breast-feeding ;

—discouraging bottle-feeding except on specific medical grounds ;

—use of contraceptive methods that do not interfere with breast-feeding ; and

—mother's milk even for babies unable to breastfeed.

As you know, the government has taken a number of steps, with the support of WHO and UNICEF, to promote sound infant feeding and weaning practices : The teaching curricula from primary schools to medical colleges are being revised. Working conditions of women are being reviewed. Maternal and child health programmes are being re-geared. Communication campaigns are being launched. Legislative, administrative and reporting mechanisms are being refined to regulate artificial feeding. But the critical role belongs to the paediatricians, not only due to the scientific knowledge you possess, but also because of the timely contact you have with mothers and children. When you see, or have knowledge of false statements, or promotional literature, will you challenge it ?

A number of other steps can be taken to bring down the infant mortality rate—not withstanding poverty—like growth monitoring, and child spacing at one level; and nutritional supplementation and female education at another level. The success of these convergent activities would depend on a basic commitment to

them by the paediatric profession. This would imply a reaching out beyond the relatively better-off clientele at the clinic to the disadvantaged majority in village or slum. It is this concern that has moved many paediatricians to set apart a day in a week or month to go out into the community to demonstrate, guide and supervise what is possible here and now. Indeed, some of the best community health services in India were started and are run by paediatricians of the highest professional calibre. I have no doubt the trend set by these examples will strengthen. But we do not have all the time in the world to let that happen :

We hope that this meeting will endorse a resolution similar to that the IPA recently endorsed in Manila calling for full support to a child survival and development revolution.

I thank you once again for asking me to participate in this national conference. This I do with pleasure and optimism.

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AN IDEA IN ACTION

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the ICDS National Convention
New Delhi on 11 November 1983

I am glad to be participating in this national convention—for the fourth successive year. There are several reasons why UNICEF attaches the highest priority to ICDS among the many government programmes in which we co-operate :

—ICDS is closest to our Basic Services Approach endorsed by the UN General Assembly in 1976. By converging an increasing number of services for the same set of disadvantaged children at the same time, ICDS stands the best chance of ensuring their development.

—Second, it has been established that ICDS does *work*—at an operational cost that India can afford. Indeed the country can ill afford not to bring together all available resources and disciplines in support of its 100 million children below the age of six.

—Third, the present phase of consolidation of ICDS holds out the promise that—steadily, and in a variety of ways—the quality and impact of the services can be enhanced and the

coverage increased until every child in need is given the opportunity to develop.

ICDS is clearly past the stage of experiment. The blocks where it operates are to demonstrate to the rest of the country, and to other developing countries, that child health and development need not lose out to poverty. Rather, one way to tame poverty is for the community—local, national and international—to see that the children of the poor receive the basic support for development. In this sense, ICDS represents more than a package of services. It is an idea in action, a lever for social change. This is why UNICEF is irrevocably committed to do whatever our modest resources permit to make it a success.

We are pleased that already ICDS has outgrown the early image of a narrow nutrition programme with some health facilities added. The spectrum of services is widening, as it should, until the physical, mental and psychological needs of the young child are met at least to an essential minimum. Where else but at an anganwadi can a child of preschool age from an impoverished tribal family hope to receive the early stimulus for its essential development?

No one has perhaps expressed, more tellingly than Mahatma Gandhi, the imperative to bestow the best attention to the first few years of the child. He said: "We labour under a sort of superstition that the child has nothing to learn during the first five years of life. On the contrary, the fact is that the child never learns after, as much as he does in his first five years." The learning capacity of a malnourished child is low. And when such a child is taken ill—as is the case often—medicines may not work and may do more harm than good. Then again, the early social environment affects the cognitive, affective and inter-personal development of the child. By providing a multi-dimensional compensatory programme for the young child, ICDS substantially alleviates the condition of socio-economic deprivation. I submit that the seminal significance of ICDS is yet to be adequately recognized by the press and the other media and therefore insufficiently appreciated by that segment of the public who are in a position to lend it support in many ways. I believe it is important to increase the visibility of ICDS, what it is achieving and its incalculable potential

for improving the quality of young life. There are many reasons why I say this.

The first relates to cost. It has been computed that the recurring costs for operating a thousand ICDS projects would be less than one per cent of the total government budget and a mere 0.13 per cent of the gross domestic product. Which means that all the children throughout the country can be reached by ICDS at a cost of less than one per cent of the GDP. Certainly this cost would not be too much if we consider a recent report that only a seventh of the 23 million children who will have been born in India during 1983 are likely to be adequately healthy and develop to anywhere near their full potential! The economic argument in favour of ICDS is as clinching as the social and ethical reasons in its support.

That leads me to suggest that ICDS projects should become the responsibility as much of non-government organizations, industrial concerns, social service groups and religious bodies as of the government. Their role could involve all or some of the responsibility for funding, managing and involving the local community. Development agencies, national and international, could support such initiatives, subject to government approval and monitoring. There are examples already of such initiatives. When these multiply, ICDS will have expanded at little cost to the exchequer and to the immense benefit of the coming generation. And a lively competition, in terms of quality and impact, will have started among ICDS projects funded by the Central Government, the States and by various agencies outside the government.

If ICDS is a valid idea, it must be applicable to all children, even those from families that are not poor. Working class parents living in large cities or factory towns no longer find it easy to give their young children the care they deserve. A strong case exists for industrial employers, in both the public and private sectors, to organize for their employees' children of pre-school age projects on the ICDS pattern. Industrial harmony and productivity stand to benefit, apart from the human value of such socially responsible action.

UNICEF in India has an intimate working relationship with a number of ministries of government. In no programme of

co-operation have we seen more ministries directly and enthusiastically involved than in ICDS. In no other programme are basic services for children joining up at the level of village and slum with such durable effect as in ICDS. This fusion of thinking and action is beginning to yield measurable results, to which UNICEF looks forward. And we pledge our support to accelerate this process.

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PLAY
AS PART OF EDUCATION

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the Afro-Asian Conference
on Role of Play in Child Development
New Delhi on 14 November 1983

At the outset, I would like to pay my tribute to the imaginative initiative of the sponsors of this conference. UNICEF views it as a sensitive expression of adult concern for an obvious but neglected area of child development.

Learning is experience. People, even children, are not educated. They educate themselves. They cannot be developed. They develop themselves.

As educators have found by experience, what is possible is :

—to promote an environment in which the *process* of learning becomes spontaneous and easy ;

—to shape the *content* of learning to make it relevant to life ; and

—to evolve a *system* of education which is accessible to all.

In the specific context of Afro-Asia, this concern has *not* found practical shape—notwithstanding the directive in the 1959 Declaration of the Rights of the Child that: "The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavour to promote the enjoyment of this right." Long before this international affirmation, Mahatma Gandhi observed—in the context of his own radical innovation in early learning in India—that the rudiments of knowledge are imbibed in the course of play, which is an essential part of education. In his perception, education implied the all-round drawing out of the best in child and adult—body, mind and spirit.

UNICEF is happy to join, on children's behalf, in this renewed quest for freedom and creativity. I would suggest, in the perspective of this conference, that these two words—freedom and creativity—signify the same meaning and value.

Let me at this stage recall a couple of typical *local* images which represent valuable insights. A recent UNICEF sponsored film on a slum in Calcutta, depicts amidst its squalour and hunger, narrow lanes and crumbling tenements, little unkempt children defying their evident under-nourishment and taking time off to play with stone and string and pieces of chalk, play happily and on their own.

Equally poignantly, a recent study (by the National Council of Educational Research and Training) of a tribal pre-school centre, under ICDS, in a backward, inaccessible village in the southern forests of Madhya Pradesh, reports how a small input of locally improvised toys and materials for *learning through play* led, in a short period of time, to a significant enhancement of the language and cognitive abilities of the children of the tribal people.

The traditional societies in Asia and Africa have a rich and varied wealth of folk games and toys which lend themselves to creative activities and science experiments for children. Through them, social interaction and an appreciation of the natural world could be achieved easily and inexpensively. There are laudable examples of such activities that exist and flourish in this part of the world. The limited coverage of each such effort is no reflection on their qualitative significance. Indeed the opportunity for

free expression of a child's personality is secure only in small groups. The urge to replicate and the craze to imitate should not lead to the facile assumption that a particular set of materials or activities would suit all children irrespective of their individual propensity, social situation and cultural tradition.

We have therefore to address the practical question of liberating children, and removing the barriers erected by adult society in the way of their self-development. I am sure this conference will generate a number of ideas for action, which we in UNICEF are anxious to consider for enriching programmes of child development that we support in many countries.

Some of the possible lines of priority action are fairly obvious. And all of them relate to changing the attitudes and capabilities, not of children, but of adults ! For example, there is a definite need to inform child care workers as well as parents how to stimulate children to play games that assist in learning. We would propose that ideas and materials for such adult learning be gathered, sifted and disseminated through appropriate channels. UNICEF is already co-operating in this area. There are other ideas awaiting acceptance and integration into programmes run by organizations with resources and resourcefulness: For instance,

—The use of drama as a form of participatory play. This has proved to be highly successful among children, including the handicapped.

—Puppetry has been tried with good result to restore self-confidence particularly to withdrawn children.

—Role-playing and story-telling have worked exceedingly well in child-to-child programmes.

The challenge before us is how to inter-mesh learning through play with on-going and expanding programmes of child development. If there is one lesson from the global experience of UNICEF, it is that the elements that support the child's development hold together, or not at all. Drinking water supply without sanitation makes little difference to child health. Supplementary nutrition may be pointless without immunization. In the absence of nutrition,

the capacity to absorb and retain, and therefore the learning process will suffer. The opportunity for children to play and learn must be accompanied by a cluster of basic services, each of them essential to the child, but none sufficient by itself to ensure the child's development.

Those programmes that incorporate all the elements that answer the development needs of children are likely to succeed. The convergence of such services has to be understood not as a final coming together of various services in the fullness of time but their intertwining, overlapping and mutual reinforcing from the earliest possible stages of, and through, the development process. When the pre-school teacher, the water supply technician, the health worker, the nutrition supplier and the promoter of the child's right to play understand each other and learn to work together for the same child, at the same time we would have under-written his or her development.

In matters concerning child development, time is of the essence. The shortage is not so much of ideas but of concerned and trained persons to work for and with children. We refer to the rights of the child. The use of the word *right* has a legal connotation and implies enforceability. If it did not, in a situation bordering on destitution, it would amount to a cruel joke. The rights of the child would be secure only through social organization in small communities asserting these rights on behalf of the vote-less, often voice-less, child. Nothing less will assure the deprived child of the right to play and to develop.

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PROGRESS REPORT
1983

of the UNICEF Regional Director
for South Central Asia

This report begins by outlining the order of the task facing UNICEF and its many allies in the Region. It proceeds to present a profile of the current thrusts of programme activity in the countries and across conventional sectors. Finally, it explains the process of applying the momentum of UNICEF experience in each of the countries, to accelerate progress towards child survival, protection and development priorities established by the Executive Board and demanded by country needs.

Proving ground

South Central Asia remains, perhaps incomparably, a proving ground for UNICEF strategies for changing the unacceptable condition of child life. To illustrate :

One in every five of the world's children is in this Region. But one in every four of the 40,000 who die each day is also here.

It is estimated that 18 out of every 100 people in the world live in poverty. Seven of the 18 are children. At least two of these

seven are in South Central Asia. Which means over a hundred million children in the Region struggle to survive, and fail too often. Most of them that do succeed live nowhere near a full life.

This picture is not new. What *is* new is the possibility, perhaps for the first time for the Region, that it can begin to change—despite present poverty. Historically, the UNICEF response was determined by the rules of co-operation with the governments, usually in vertical schemes. This partnership was, in effect, necessarily conditional, often isolated in its outcomes and, when it worked, ameliorative at best. Today, experience, assessment and awareness of the limited values of that approach, have led increasingly to co-ordinated approaches to a multi-faceted problem—by governments, by most of the development promoters and by UNICEF.

Changing framework

This is the setting in which the framework of UNICEF co-operation is itself undergoing change, which is perhaps the most significant shift from tradition during the year in each of the countries of the Region. In **Sri Lanka**, a Children's Secretariat is in position within the government, reporting directly to the President. Its capacity to influence policy and action has already been demonstrated—in getting the code of marketing breastmilk substitutes ratified under the Consumer Protection Law, and in several other areas. The co-ordinating role, on children's and mothers' behalf, of the Ministry of Social Welfare in **India** is increasingly recognized by the other arms of government, and reflected in the planning process presently engaged in shaping the seventh development plan beginning 1985. In **Bhutan**, His Majesty the King is the moving spirit for radical departures in policies, procedures and programming relating to children. The **Nepal** government commitment to the principle of people's participation in the development process has found practical expression in two ways : the coming into effect of the Decentralization Act which enables and legalizes district level planning; and also in a number of child-related programmes, for example, through well-organized group activities by small farmers and women. The government leadership in **Afghanistan** has taken seriously to the tasks of children's development. The national code of marketing breastmilk substitutes is

an illustration of this change. In the **Maldives** a National Council for Mothers and Children has been formed with the President as its chairman. All of these are propitious gains of durable value for strengthening on-going programmes and launching new ones, whether or not UNICEF is a participant.

It is significant that *Decentralization* of the planning process and administrative procedures is becoming pronounced not only in **Nepal** but also in **Sri Lanka** and **Bhutan**—as a response to experienced needs. District planning is likely to be a major feature of **India's** seventh five-year plan. We read in this trend, a self-propelling process and a fruitful prospect for UNICEF co-operation, for our basic services approach is geared principally to the level of the sub-national community.

Hopeful features

As a concomitant of these developments, there has been a recent spurt in *national budget allocations* for the social sectors, in monetary terms, and in **India** as a proportion of total spending. This has happened despite the general squeeze on public revenue in some countries, and the earlier familiar tendency to axe the social sector budget ahead of other sectors when money becomes scarce.

There is another feature that reinforces guarded optimism on children's behalf. There are a number of emulative examples of dedicated voluntary effort, in isolated pockets scattered through the Region. These are almost always against tremendous financial and organizational odds. They are active and productive, often in a multi-dimensional field, and vindicate through daily practice and achievement, the principles of primary health care, basic education and other elements of the basic services approach. They provide a demonstrable lesson to governments as well as UNICEF on why and how things do work in particular socio-cultural settings, poverty notwithstanding.

In a context of development experience as vast and varied as in this Region, the basic tenets of UNICEF policy have to be interpreted not only as separate strands of a strategy on behalf of children and women but rather as a unifying principle coming

under the rubric of a democratic theory of development. We see here the exciting prospect of concept and practice nourishing mutually, a challenge of the first order for an organization with modest resources and historic aspirations.

The strongest hope for success comes from a simple truth: However different in nature the regimes in the Region may be from one another, each of them is persuaded, largely by the negative experiences of the past, that social and human development can be neglected only at unacceptable risk. This perception derives from the political education to which the people of the Region—even the unlettered majority—have been exposed. The democratic ethos is visibly strengthening—despite, perhaps because of, the darkness of our times. It is more than coincidental that the Basic Services approach involves something more than what is usually called community participation—it is based on human rights and responsibility, individual dignity, and social equity.

Political will to achieve progress for people—most of whom are children is strong. Examples: of the 20-point programme in **India**, 12 are directly related to human development (and UNICEF collaborates with 8); in **Bhutan**, His Majesty the King has stressed the improvement of services for people. The leadership of **Sri Lanka** has continued to push forward on social issues; the President of the **Maldives** personally leads the National Action for Children. The Chiefs of State and Heads of Government in each country of the Region were the first to endorse the message of The State of the World's Children Report.

Operational hurdles

All the same, it would be over-romantic to ignore the obstinate operational hurdles in the way. This Region which has largely escaped the contemporaneous or lagged effects of global recession still bears some of its scars. This is notwithstanding the insularity of a good part of the economies on account of the non-monetized nature of traditional transactions in the rural areas.

The shrinkage of aid resources in particular and of foreign earnings in general in a country like **Nepal** (which is heavily dependent on them) has led to a pruning of the government budget and therefore

of social service investment. Add to this a substantial failure on the farm front, the resource stringency becomes worse. Yet major health projects with UNICEF and WHO collaboration like maternal and child health, family planning and goitre control have received substantially higher financial support for 1983-84 than in the preceding year; and EPI retains nearly the same level of funds allocation.

The **Sri Lanka** situation presents similar reasons for anxiety in a somewhat dissimilar context. Rice production has fallen; and resources generally are scarcer. There the socio-political risk is in having to climb down by a few notches from the levels of social sharing and well-being established earlier.

There is an aggregate self-sufficiency in foodgrains for **India** where agriculture is currently on the upswing, the savings rate is high and inflation is moderate. Which is not to imply that the zones of poverty are receding, that the savings find investment in production for consumption by the majority or that productivity, as measured by capital-output ratio, is rising or reasonable. These represent the unmet challenges—starkly capsuled in a recent FAO finding that India has over 200 million malnourished people. If their counterparts in the other countries of the Region are also taken into account, the total then chalks up nearly half the world total of the malnourished.

Facing the challenge

The Region's share of *diseases* and the toll they take continue to be heavy. The past year saw, in particular, an outbreak in epidemic proportions, of meningitis in **Nepal** and of diarrhoea in **Sri Lanka** and **Maldives**. To these UNICEF responded in every way it could, but prevention, or even control, remains some way away. Malaria has staged a rapid resurgence and needs to be tackled in ways yet unclear. A recent UNICEF-sponsored study revealed an alarming extent of iodine deficiency in **Bhutan** (just as in large areas of **India**, **Nepal** and **Afghanistan** and possibly a few places in **Sri Lanka**). A massive and renewed response, in **India** and in **Bhutan**, is now under preparation.

It is no cause for comfort that in the Region, the majority of the people (and in some countries an overwhelming majority) remain

illiterate, without access to safe water or elementary sanitation. The answers are known, the political leaders are keen, the people have been waiting; yet results have been slow in coming. UNICEF is planning, indeed already applying, major inputs in these directions: for example, the Universalization of *Primary Education* and Literacy in **Nepal** (where the female adult literacy rate is six, as of 1980). Today, a majority of Nepalese children are, or have been, enrolled at school. Even in **Sri Lanka** with its high rate of adult literacy (87), some 15 percent of school-age children are out of school; and the disparity in standard between school and school is glaring. UNICEF and UNESCO are with the government in addressing this situation. We are, to mention another instance, assisting **India** towards the decadal goal of reaching safe drinking water to 100 percent of rural areas: In the past year over 20 percent of the total number of water wells drilled in the country were made with UNICEF contribution. UNICEF played a part also in recently upgrading the priority accorded by government policy to environmental sanitation and excreta disposal.

It is all too easy and common for development promoters in this part of the world to feel frustrated. Among the self-given rules of UNICEF is the steeling of its own will against despair. It is in this spirit that the programme thrusts adopted in the countries in 1981 and encouraged and sharpened by the State of the World's Children Report have been carried forward. These are discussed in the following part of this report.

Closing the gaps

Due to historical reasons, the countries of the Region share much the same pattern of administrative organization. In this, public health and school education are traditional components, unfortunately, and too often, separated by some mental distance. Nutrition of the child and mother is relatively a new concern of public policy; water supply and sanitation are severely confined to, yet inadequately covering the towns. There is no way, perhaps no need, to supplant these sectoral categories by separate services for women and children. What is possible and is being incrementally achieved is to reduce the time, space and aims that separate one basic service from another, one discipline or profession from another, one function and another, one organization or group and

another—on the strength of a concern already shared, or encouraged to be shared.

Those programmes that incorporate all of the several elements that answer the survival, protection and development needs of children are likely to succeed. Not the others. We have therefore tried to re-interpret the concept of convergent services in the course of its practical application. The convergence is not a final coming together of various services in the fullness of time but their intertwining, overlapping and mutual reinforcement from the earliest possible stages of, and through, the development process. When the pre-school teacher, the water-supply technician, the community health worker and the nutrition promoter understand each other and learn to work together for the same child at the same time, we will have underwritten the child's development.

Programme orientation

In programme terms this implies weaving the warp of sectoral services like water, nutrition, primary health and early learning into the weft of people-specific and area-based activities like the Integrated Child Development Services and Social Inputs for Area Development in **India**, the Small Farmers' Development Programme and the Women's activities in **Nepal**, the Mahaweli and Estates projects of **Sri Lanka**, and the urban slum development activities in **Afghanistan, Sri Lanka** and **India.** These are described and critically analysed in the monitoring and annual reports from each country. Suffice to add that, given the backlog of poverty, the scarcity of resources and the rigidity of inherited attitudes, there is perhaps no known alternative to bringing sectoral services in this manner to focus together on the neediest. This pattern is spreading in the countries, offering the highest single hope, for moving steadily to scale. This does not mean that every effort at area-specific development is succeeding. But those that fail, do so not because the concept is fragile, but because the sectoral services are unready or unwilling, for whatever reason, to pull together through the process of planning, implementation and monitoring. In turn, we have been able to pinpoint this unpreparedness mainly on the inadequacies of a training that puts greater emphasis on techniques than on attitudes. Accordingly, one of the tenets of UNICEF co-operation has been that technicians and professionals should be

exposed to the aims of one another's disciplines and all of them trained, like community workers, to respond naturally to the needs of the most vulnerable.

The inexorable merit of this logic is coming to be recognized. We perceive that the distance between education and health is reducing slowly, until, we hope, there is a healthy overlay of the two in support of the child and family. Knowledge is the basic means to empower people to secure their health and to reduce undue dependence. So too, nutrition becomes a matter as much of education in the use of food as of access to it. And the wall between health and nutrition is coming down, again very slowly. As part of the same process of fusion, the overlap of nutrition with agriculture, education, health and environment is being recognized in practical terms all the way from pre-school centres to agricultural universities. It has been possible, notably in **Nepal**, **Bhutan** and **India**, to transform the Water Supply and Sanitation programme from a conventional technology-based endeavour to one that responds to the expressed needs of a participating community.

Influencing attitudes

One of the UNICEF aims of this Region is to assist, however modestly, in the shaping of a new kind of professional who can see beyond, and venture out of, narrow disciplines—to understand life as it is lived in village or slum. All the learning programmes that UNICEF supports, pursue this possibility, from the primary school curricula to the medical college courses. The UNICEF contribution (not necessarily unique) to this process of attitudinal change is in persuading public opinion that health and education are, for example, not just medical or pedagogic pursuits but represent essentially social aspirations.

This is the programme orientation within which it has been possible to emphasize the particular priorities highlighted by "The State of the World's Children." The task of persuading government functionaries and non-government organizations was made easier by the public statements issued by the Prime Minister of India and the President of Sri Lanka. The President of India and the King of Bhutan also expressed themselves fully in favour of the UNICEF

initiatives. Mother Teresa lent her invaluable support. Leaders of the medical profession endorsed our approach. Parliamentarians, as in Sri Lanka, agreed to give a hand collectively as well as in their own constituencies. In all the countries, the media were unreservedly responsive. The credit for such success as we have come by in infusing ongoing programmes with the SWCR priorities and in developing new programme components belongs therefore not to us entirely, but substantially to the opinion-makers in the countries of the Region.

Improved infant feeding

As mentioned, **Sri Lanka** and **Afghanistan** have adopted national codes of marketing of breastmilk substitutes. In **India**, the government-owned radio and television have decided not to carry advertisements of baby foods. The Ministry of Health has advised the State governments to instruct their staff not to accept free samples of baby foods and feeding bottles, and to actively promote breast-feeding. While legislation of the national code is awaited and persuasion by UNICEF continues, these steps suggest the government's commitment to the spirit of the Code. In **Nepal** and **Bhutan**, nearly all mothers breastfeed their children but the reverse trend among literate and employed women has been noticed. In these two countries, improper and delayed weaning is the main obstacle. Similar is the case in **Afghanistan.** The situation in **Sri Lanka,** though different, is not much better. A recent study by a women's group suggests that 78 percent of rural and 22 percent of urban mothers breastfeed. This apart, weaning is deferred upto even a year, with disastrous consequences reflected in acute undernutrition of children between 6 and 24 months. Which suggests that legislation can only be a first step and indeed the educational campaign must not wait for it. Even in the case of breastfed babies, it is common, as in **India**, that breast-feeding actually starts after the first few days and stops within the first few months.

In this situation, a systematic effort has been made during the past year in a number of ways. The existing curricula for nurses, midwives and health workers, as well as the medical profession are being changed to emphasise proper infant feeding practices. Public information campaigns have been stepped up. The analysis

of the considerable feed-back proceeds apace, to be appropriately relayed back to the public. A series of workshops for medical and para-medical workers are in progress at national and sub-national levels as part of a communication strategy to disseminate on a massive scale professional information through professional channels. Basic messages on breast-feeding and weaning practices have been, or are being, inserted (a) in primary school textbooks, teaching materials for community education, non-formal methods of learning for women and out-of-school children, in school curricula on nutrition and health education; and (b) into every programme of UNICEF co-operation—from training and advocacy to cash assistance and supplies; from pre-school centres to water supply operations; in development projects in tribal areas and in urban slums. In fact, UNICEF assistance is made conditional on the articles of the Code being respected in practice. Paediatricians in general are supportive and in **India** through their own professional association, very active in public promotion of improved infant feeding practices and acceleration of immunization coverage. We are supporting or bringing out a number of studies and publications on the subject of sound infant feeding practices.

As part of our ongoing effort to strengthen the interface between agriculture and nutrition, we have succeeded in persuading agricultural universities to launch correspondence courses and newsletters on proper infant feeding practices. Workshops are being conducted to orient radio and television producers and other communicators towards this simple answer to a continuing nutritional depletion on a social scale. Quick evaluations show an impact; which is being built on.

Towards universal immunization

We have found the governments responsive to the suggestion to accelerate the pace of immunization coverage, to try alternative operational strategies, to include measles as a regular component of the schedule. For our part, we have extended support (and are willing to do more) to close the gap in vaccine availability through indigenous production and/or import. We have helped production units to augment their capacity. We have assisted in strengthening the cold chain through all its stages—by funding supplies, repair and maintenance facilities and training courses for project staff

from governments, NGOs and UNICEF itself. We have encouraged alternative patterns of organization and delivery. We have offered co-operaton in support of improved and expanded logistics and management. Information campaigns have been launched and are sustained through a variety of media.

Practical problems of infrastructural weaknesses are being faced. Even in a country as difficult logistically as **Nepal**, 46 districts out of 75 have been reached. Access does not however mean actual coverage. In **India** where the access is better, the coverage during 1981-82 ranged between 9 percent for polio and 29 percent for DPT, with measles hardly in the picture. Even in urban **Kabul**, the coverage may not be more than 30 percent for any vaccine. **Sri Lanka** is better placed with average coverage near or over 50 percent. But even here averages hide the backwardness of some areas. Our perception is that universal immunization by 1990 is feasible. Though a major organizational challenge, it can be met, given a firm political lead which will be welcomed by numerous non-government agencies active in their own spheres.

There are several hopeful factors on the immunization front. Measles which annually affects over 15 million children in the countries of South Central Asia and kills a quarter million of them, is being included in the government immunization schedules of **India** and **Sri Lanka**—for the first time. In **Sri Lanka**, there is a dramatic drop in the incidence of immunizable diseases—at immunity levels offered by the present coverage which ranges from 47 percent for TT (2) to 79 percent for DPT (1). Even in a more vast and complex setting like **India**, it has been demonstrated that in backward areas with weak public health systems, EPI programmes can achieve expected results, given the lead. A demonstration of different approaches was the success in the intensive campaign in the Devas district of **India**—and, dissemination of the news through audio-visual and print channels has encouraged others. In another district (Bidar), the existing health infrastructure is being successfully re-geared to move towards universal immunization. These examples apart, area-specific projects, like ICDS and SIAD in **India** and comparable projects in the other countries are progressing (though not always at the maximum possible speed) towards greater coverage. Significantly, these are located mostly in backward areas. And they, together with the conventional channels

like health centres and planned campaigns by health ministries and non-government agencies, offer the best hope for moving to scale on immunization.

As in the case of infant feeding practices, immunization is promoted through *every* UNICEF-assisted programme activity : for example, curricula for primary schools, women's literacy, nutrition and health education; training, advocacy and information programmes relating to childhood disability and destitute children; child-specific and area-based services, prominently including **India's** vast network of ICDS projects.

Our effort is guided by the lessons of our field experience, which may be summed up thus : universal immunization is feasible as of now ; success depends on strong institutional and community linkages; supportive communication must precede and accompany the campaign using a variety of methods, messages and media; seasonal factors will have to be taken into account in programming for immunization; the education by whatever means of girls and young women (most of whom are illiterate) is crucial for full coverage—illiteracy and ignorance being the biggest constraints. We support the idea of building up rapidly the production and logistics capacity while simultaneously helping to create a public demand for protection based on awareness of the value.

Social priority for diarrhoea management

We cannot yet claim that home-based oral rehydration therapy has captured the imagination of professionals but it has registered its presence in the relevant places. Diarrhoea management is a social priority in **India, Sri Lanka** and **Maldives**. Even in **Nepal** and **Bhutan**, it presents a major problem. The compulsions of the current circumstance (in which some one and a half million young children die of dehydration in the countries of South Central Asia each year) will lead to its being recognized and acted upon as such. Our effort is to hasten the process.

We are advocating ORT, packaged or home made, at the level of the mother, the health worker and the medical system. We are promoting local manufacture of packets by women's groups (**India**) and by government companies (**Nepal, Afghanistan** and **Sri Lanka**) and

encouraging the use of ORT in all programmes of UNICEF co-operation. We are helping to introduce it as part of the training of a whole range of development workers—from health guides to handpump caretakers. ORT is "infiltrating" the delivery systems. The market outlets will not be slow in catching up.

In **India,** UNICEF is active in promoting and formulating activities to support the National Plan of Action to control diarrhoeal diseases as part of primary health care. This leads to distribution of packets through some 58,000 outlets in the public health system. There is also a parallel intensive programme of motivation, training and orientation in the effective use of ORT through these centres. ORT is inserted in teaching, training, information and advocacy efforts in all current programmes. Low-cost learning materials for mass production of home-made solutions have been prepared. These are being used in non-formal education of women and girls. A joint WHO-UNICEF slide-sound presentation, "A Simple Solution," has found approval with policy-makers and professional groups in India ; hundreds of copies are being released for country-wide showing. Large-scale production/import is supported by UNICEF in **Nepal**, and import to the **Maldives.** In **Sri Lanka** UNICEF imports packets for use in rural areas. We are helping the government there to increase capacity for local production. Availability has to increase in all the countries ; even more, acceptance and actual use has to be promoted. Here again, it is obvious that usual programme support and inputs **must** be accompanied by public promotion through all social communication channels to move to scale against the problem.

Meaningful monitoring of growth

Growth monitoring from birth to five years has been accepted by the countries in the Region as a responsibility which the health profession shares with the mother. This does not mean there are enough cards for distribution or that the available cards are put to proper use. The supply of weight-for-age cards is kept up mainly through government channels, like the Nutrition Cells of **Nepal.** Hundreds of thousands get distributed in **Sri Lanka,** millions of them in **India's** ICDS alone. We have found that growth monitoring, by whatever method, becomes meaningful only in conjunction with health care, and nutritional support, including

water. Moreover, without carefully prepared and tested support materials, training and acceptable communication, *repeated* and *continuous* use cannot be assured.

Some 100,000 copies of the manual for health guides were printed in Hindi during the year—laying the foundations of proper training to monitor, and to assist in ensuring nutrition and health. How well a growth chart is used depends on the persistent devotion of those who handle it. Which argues that the mother, even one who cannot actually make the entries, should keep the card and get it regularly filled in and referred to. Our aim is to promote the use of growth charts as part of a system of services (formal or not) reaching the child. The present phase is one of demonstration and propagation, preparatory to use as a regular tool of nutritional and therefore health surveillance—and use on a massive scale. Concurrently, questions of logistics, supervision, and evaluation are being addressed. For example, the tools of growth monitoring—like growth cards, measuring tapes and circumference strips and weighing scales—are part of standard equipment for child development services, the simpler items figuring in the health volunteer's kit. Meanwhile, a study is in progress to assess the perceptions of illiterate mothers in deprived groups about the growth chart, its maintenance and use.

While there is nothing new about growth charts, growth monitoring is yet to become a regular feature of child health services or a normal routine in homes. The answer, once again, lies in making it a part of the training and informational dimensions of every ongoing and new programme on the one hand, and effective public social communication, on the other. For our part, we are insisting on this in areas of our co-operation with and outside government. We have also learned that to be effective *all* organized groups must be approached and enrolled into public support for these measures.

Ways to supplement nutrition

Nutritional supplementation has long been a concern of UNICEF. The most important practical expression of it has been and is the dissemination of nutritional knowledge, appropriate to the stages of pregnancy, breast-feeding, weaning and beyond. How best to

use and share available food is one aspect of nutritional promotion; how to augment the family's capacity to improve its access to food is another; how to feed the hungry till they acquire the ability to feed themselves is a third. In a situation of inequality and consequent poverty, the public as well as individual responsibility extends to all the three approaches. Lately, there has been a willingness on the part of governments (some States of **India** for example) to implement policies of subsidized food (even as **Sri Lanka** has, since 1979, modified this policy through the mechanism of food stamps). In effect, millions of children in Tamil Nadu, Kerala and elsewhere receive a nutritious meal at school. And millions of pre-schoolers and hundreds of thousands of pregnant women have it as part of the Integrated Child Development Services in **India**. (Further studies in 1983 continue to show reduced rates of death and morbidity and the cost effectiveness of this approach.) Today in **Sri Lanka**, fully half the population, or 7.6 million people, benefit from subsidized food supply—apart from government supply of nutritious foods for children and thousands of community kitchens run by non-government organizations like "Sarvodaya." The point to note is that public policy is increasingly finding that political and social gains are far greater than the considerable, recurring economic costs of feeding programmes. We welcome and where possible assist these initiatives but advise that the earlier they come in the child's life, starting in the womb, the more cost-effective they will be.

This however is not at the cost of the fundamental UNICEF promotion of self-reliance of communities and families in appropriate nutritious low-cost foods, through enhanced local production. This is systematically emphasized, on the one hand, through collaborative programmes of agricultural universities, training centres, and home science colleges; and on the other hand through area-specific development projects, including income-generating activities by women.

Meeting massive micro-nutrient deficiencies

An equally important area for early intervention is the widespread deficiency of micro-nutrients like iron, iodine and vitamin A. The past year has been one of pointed advocacy for lasting solutions. There is a clear case for Regional co-operation in the

technology of large-scale production and distribution of iodated salt. Upto 200 million people in the Region may be suffering from iodine deficiency in varying degrees. UNICEF funded the setting up of a number of plants in **India** to manufacture iodated salt for India and neighbouring countries. While this system of production and distribution exists, its coverage and efficiency are unequal to the extent and gravity of the problem of iodine deficiency disorders. As an emergency measure of prevention, UNICEF has been funding iodinated oil injections in **Nepal**, the population coverage having risen over the past two years from 55 percent of the target population in endemic districts to 84 percent or 1.1 million people. The present effort is to extend the current coverage of 61 percent for women in the reproductive age group of 15-45 years. UNICEF collaborated with a government medical team on a pilot project for giving iodinated oil injections to a population of 10,000 in the Gonda district of **India**, where the prevalence of goitre was more than 60 percent. Evaluative resurveys are in progress; these should help the current process of making the national goitre control programme more effective. The feasible answer appears to be to use iodized salt exclusively for consumption throughout the country. This aim is being pursued vigorously in **Bhutan**, where a recent UNICEF-sponsored study revealed an appalling goitre rate of 60 percent for the country. The Plan of Action for **Bhutan** is ready including supplies, equipment, expert talent, and a tested public awareness building scheme. Our willingness to assist other programmes has been made known. Governments' response will be clearer as specific proposals, renewing old ones or outlining new ones, are put across in the coming months.

UNICEF has been and still is a provider of vitamin A tablets. Considering the massive and continued need, it is unlikely that our role will taper off as expected at one point of time. The long-term answer lies, once again, in nutrition education and appropriate diets based on available local foods rich in vitamin A.

Iron deficiency anaemia is far more widespread in the Region than even iodine deficiency disorders. The problem is old but it calls for a fresh approach to a known answer. In **India**, a UNICEF-supported action-research co-ordinated by the National Institute of Nutrition revealed that iron-fortified common salt is scientifically feasible and socially acceptable. We are currently investigating

how to move to scale. In **Sri Lanka**, more than half the number of pregnant women in the lower economic strata are assessed to be anaemic. An estimated 40-60 percent of pre-school children and 50 percent of pregnant women in **India** are anaemic. As in the case of iodized salt, UNICEF stands committed and ready to respond to governments in every way it can—on the highest priority.

Fewer deaths, fewer births

The UNICEF contribution to birth spacing has been indirect—by promoting child survival and the mothers' knowledge that the health of both mother and child will be better if there were fewer births and longer intervals in between. True, the growth rates are high in all the countries in the Region, and very high in the **Maldives** (3.8) and **Nepal** (2.6). Even the latest available figure for **India** (2.1) is considered by the government as excessive. Both the Governments and UNFPA are active in the field. UNICEF can play its part by decelerating the infant mortality rates, presently high in most countries : 182 in **Afghanistan**, 146 in **Nepal** and 125 in **India.**

Learning for mothers and mothers-to-be

Except in **Sri Lanka** and a small part of **India**, namely Kerala, female (as well as male) education has a long way to go. The comparative female adult literacy rates are 82 percent in **Sri Lanka**, 25 percent in **India**, 6 percent in **Nepal** and around 4 percent in **Afghanistan.** Apart from participating in programmes common to all learners, a number of schemes operate—for example : the **Nepal** project : Education of Girls and Women, for supporting girls from remote areas and disadvantaged groups while they finish schooling and are themselves trained as primary school teachers; the National Non-Formal Education Programme for Women and the ICDS component of Functional Literacy for Adult Women, both in **India.** In addition to the massive formal school system, **India** has some 80,000 non-formal centres. A typical instance of current UNICEF collaboration is the production of a literacy primer for women which weaves literacy-training with learning content relevant to child care and development. Here again, the challenge is one of moving to scale by working together with organizations of and outside government and working through conventional or

alternative channels and established or innovative methods.

Allies in a common cause

We started this report by considering the magnitude of the task facing governments (and UNICEF) in this Region. We conclude by noting that neither can fulfil it singly or even together. As it takes people to help people, the people and their resources have to be organized and mobilized in support of child development. Governments can help and speed up this process. UNICEF can advocate particular policies in the light of its experience and support actions (necessarily on a limited scale) that run the risk of being deferred or overlooked but for such intervention.

This is the context in which UNICEF in this Region has paid the highest attention to seeking out allies who share our concerns and agree with our prescriptions. Their primary role is to communicate with their constituencies and to influence people to act together on behalf of the deprived child. The objective of advocacy is to make a concern for and action for children, everyone's business.

We can claim that during 1983 we have found more groups responding to our initiatives than we had hoped for. The media are obviously more conscious than ever before that a design of development that by-passes the needs of children would be unsustainable. We have reason now to look forward to a more dynamic leadership role by the media in moulding public opinion in support of existing or emerging national policies for children. Parliamentarians are taking a new interest in matters concerning children from deprived homes. Policy-makers have begun to accord a place for children and women in the process of development planning. This is an innovation even in a country like **India** which has a sophisticated planning apparatus. We promote the idea that children are *the object* of planning for development. The professions or at least some of them, are able to look beyond their immediate practice and see a wider social dimension to their roles.

In this climate, UNICEF has strengthened ties with old allies and found new ones. An educational alternative to rote-learning for wage employment is emerging and UNICEF is counted among the more consistent of the pro-changers. Those who seek to

protect the environment from what often passes for "development" find UNICEF speaking much the same idiom. Those who support decentralized, community-based development broadly agree with our approach to a shared problem. Religious leaders have responded positively to the elements of the basic services strategy. So too service clubs, vocational groups and employers' associations.

These categories are mentioned because fruitful interaction with them has been part of our experience this past year. We believe this process will mature into viable acceleration in the coming months.

As has been reflected in all the country annual reports, UNICEF in this Region has close working relationships with a large number of non-government organizations, themselves in the forefront of the development effort in remote villages and depressed urban slums. We see these ties growing within the framework of co-operation with governments.

The existing partnership within the UN system is strengthening with time, again inevitably. A joint consultation on nutrition has begun in **India** with all UN and some bilateral agency participation. UNICEF is working closely with WHO in all the countries in a number of fields, the most recent being the Joint Nutrition Support Programme in **Nepal.** The partnership with IFAD, UNESCO, UNDP and the World Bank is close in **Nepal** and strengthening in the other countries. New possibilities are opening up in each county with the UN agencies dedicated to development, working closer together. The relationships are growing with official bilateral groups: CIDA, NORAD, SIDA, USAID, and bilateral aid agencies of the Federal Republic of Germany, Australia and Italy.

And finally, the countries of South Asia see for themselves an exceedingly rewarding field of co-operation—for the development of children. For example, control of iodine deficiency disorders is a natural and priority subject for joint action. The pace of such coming together cannot be forced, but when it happens, a known stand of UNICEF and WHO will have been vindicated.

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MEDICAL EDUCATION FOR CHILD HEALTH

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the 23rd Annual Conference of the Indian Association
for the Advancement of Medical Education
New Delhi, 16 January 1984

Education and health—of, by and for the people—are prime movers of social progress. It is only natural that these should focus primarily on children who—after all—have the highest potential for development. This briefly is the perspective in which UNICEF sees the relevance of advancement of medical education, and the theme of Child Health Care chosen for this Session. We are naturally delighted to participate in this influential discussion. And we look forward to its accelerating impact on current efforts to formulate a national medical and health education policy, in pursuance of the National Health Policy announced two years ago.

From the beginnings of UNICEF co-operation in India in the late Forties, our involvement in the field of health has been more intimate than in any other sector. And our collaboration with the medical profession has been closer than with any other professional group. This continuing relationship encourages us to present a few observations on the health system in general and on medical

education in particular—in the context of child health and development.

I will first touch on what I perceive to be certain broad characteristics, positive or negative, of the present situation; proceed to add my own support to proposed and needed changes in policy; and finally suggest some possibilities for action which may be taken right away by the medical profession to transform child ill-health into child health, without waiting for structural changes in society, again so obviously called for.

UNICEF views the present phase as one of transition of a public health system developed in a particular historical context into another, more suited to a democratic society. The trend is evident and unmistakable but the time it is taking to come into its own is unacceptable in the social sense. The task of all of us is to strengthen the trend and compress the time.

The UNICEF concern with child health and development is predicated upon the effective emergence of what the Bhore Committee of 40 years ago termed the "social physician." We understand this ideal as an alloy of professional competence, social concern and leadership quality on the part of a medical doctor who would assume the responsibility for the health of a defined population group, insofar as the people cannot ensure it on their own. The essential function of a doctor is suggested by its original meaning of "teacher." We note with concern that this vision is, by and large, yet to be realized. How to move towards it is, in our view, the crux of medical and health education.

Fortunately there is little that can be added to the wealth of insights contained in a series of reports by leaders from the medical profession itself: such as the committees linked to eminent names like Mudaliar (1962), Mukerjee, (1965), Jungalwalla (1967), Kartar Singh (1975), Shrivastav (1976) and Ramalingaswami (1981). The sum of these reports points to the need to establish a harmonious and dynamic balance between clinical and community medicine, medical doctors and para-medical workers, health services and medical colleges, common ailments and esoteric concerns, theoretical knowledge and practical priorities. Given the pre-existing bias, this implies major correctives in

directions in which considerable preparatory action has already been taken. Decisive steps will have to follow.

For example we should be greatly encouraged by the fact that the health infrastructure has been developed to a potential which could permit preventive and social medicine to be practised successfully and countrywide. Nearly 6,000 primary health centres, more than 70,000 sub-centres, some 250,000 community health volunteers are in position. This means that on the average 100,000 population will have a primary health centre, over a dozen sub-centres, around 50 medical and paramedical employees and a hundred or more community health volunteers. This is apart from other major health-related facilities like the Integrated Child Development Services (ICDS) which would cover in about a year's time a fifth of the development blocks in the country. And there is the vast strength of tens of thousands of private medical practitioners. If access to health for all is not achieved in appointed time the reason will not certainly be any lack of infrastructure! Rather it will be related to the orientation and capability of the health professionals and supporting cadres—the health workers. Their education, orientation, and motivation are therefore the key to change.

The imperative for change is underlined both by the functional weaknesses of the existing health system despite its impressive spread, and the social challenge posed to it by the goals set for the current century. The life expectancy is 52 years against a target of 64, crude mortality 14 against 9 and infant mortality 125 against 60. Against this background, the importance of reducing child mortality becomes crucial, in a country where children comprise over two-fifths the total population. For, 45 percent of deaths occur below the age of 5 years, more than half in infancy. And the first month of life accounts for half of infant deaths due to low birth-weight, neo-natal asphyxia, tetanus of the newborn and other intra-partal problems. In the first year of life diarrhoea and pneumonia claim the bulk of deaths, aided, of course, by malnutrition. And immunizable diseases, prominently including measles, continue to claim a large number of lives in spite of availability of effective vaccines. It is the considered view of UNICEF that this dismal picture, related largely to rural communities, can be changed and that the national health targets including

an infant mortality rate of 60 are attainable within the time, resources and technologies presently available in india. The point at which people, resources and technologies can be efficiently marshalled to a common purpose is in medical education—in the initial training and orientation of all health workers and in in-service upgrading of knowledge and skills.

It is hardly necessary for me to go into the means and methods of strengthening this dimension of medical education—beyond conveying our broad support to certain proposals already widely discussed.

For instance, most of the present training of graduate doctors is examination-oriented, didactic, clinical and curative in emphasis. Students become at best clinical curative doctors with little knowledge of, or interest in community interaction or in leading a health team with a measure of managerial competence. Even where social aspects of a disease are recognized, there is only marginal involvement by the health services or medical colleges in coming to grips with them—barring an exception or two which only prove the rule. Even where medical colleges have tried to reorient medical education in the direction of community health, often they have only moved clinical curative services into the community rather than accepting the responsibility for the health of the population. Such a responsibility should be understood not so much in terms of *providing* health services, as in *working together* with the community for its health. This concept implies that the experience of living and working with the community and para-medical personnel—who should be considered colleagues—should become a substantial part of undergraduate training. And the examination process leading to the medical degree should be concerned equally with clinical and community tasks. This concept should be extended to internship.

The view is widely shared that the present examination system is the major single obstacle in the way of comprehensive health care at the village level. As of now, community experience, clinical competence and supervisory capabilities are of little help in passing examinations. It is even arguable that students deeply involved in community work tend to suffer in the present system. Unless this is changed through appropriate curriculum design, training

methods, evaluation techniques and continuing medical education, it is unlikely that Indian doctors can assume the leadership role in their own country's advance towards better health through primary and preventive care.

A useful criterion to identify a "social physician" would be the time he or she spends in curative services. It has been suggested that medical officers in the health service should be encouraged to spend less than a quarter of their time in curative services, making greater efforts to delegate these tasks and allowing themselves more time to administer the health system under their control. This presumes that medical personnel may willingly take up a career of providing health care in rural areas. The presumption would be valid only if undergraduate training and orientation is radically reshaped towards that end. Even postgraduate training in preventive and social medicine could be geared, much more than now, to the practical needs of the public health system, based on an epidemiologic understanding of diseases.

Childhood diseases in India are well-known—their prevalence, locations, causes and consequences. Certain priorities are dictated by them in the context of the present, and prospects in the nation's future. These priorities cannot wait until reorientation of medical education is achieved. The answers made available by medical science and development experience have to be applied here and now before further irreversible damage is done to the country's human resource.

For example, every 10 seconds, somewhere in India a child is struggling for life against diarrhoeal dehydration. The answer is known, uptodate, scientific, safe, inexpensive, practical and effective for 95 percent of the cases of diarrhoea. But unless it is used, on the initiative that rests with the medical profession, it will remain a mere potential. A national programme of diarrhoea management exemplifies the opportunity for practising some of the principles we have discussed earlier in the context of reshaping medical education. This would mean that :

—Mothers give the home-made oral rehydration solution to prevent dehydration;

—Health workers use ORS packets to correct mild to moderate dehydration; and

—Health centres and hospitals provide intravenous therapy to treat severe dehydration.

A complementing design such as this for team work in community health is what primary health care is about. Even as medical students are "educated" on it, medical practitioners in and outside government can set a trend—to the immediate and lasting benefit of children among the poorer segments of society.

The same principle applies to equally simple, but socially vital, primary health interventions like measuring weight and height for age, without which neither mother nor health worker nor paediatrician may notice growth faltering in time to arrest and reverse it relatively easily. Thus it becomes a function of the community health system, under the leadership of the medical doctor, to make weight and height (or length) measurement possible for children from poor communities.

We all know that the best protection against six of the most dangerous diseases of childhood is complete immunization during the first year of life. There is no technological or financial reason for India not to achieve universal immunization within the next few years, despite the relatively low coverage at present. Priorities in medical education have, once again, to be established through social priorities in medical practice. In our co-operation in this in India we are often brought to a standstill by evident lacunae in knowledge of principles of immunization. It is still beset with taboos, superstitions, out-dated practices with regard to contra-indications, vaccine control, schedules and recording and reporting systems.

There is no longer any argument about the mother's milk being the best food for the infant. But promotion of natural feeding, in the face of the commercial competition of artificial substitutes, will not be possible unless scientific knowledge is communicated to the community through the influential channel of the medical profession. As curricula are slowly being reshaped on this and

similar priorities in health and nutrition, the example set by the practising professional is crucial.

Preventive and promotive health care remains, for a cluster of reasons, the Cinderella of medical education and practice which is unfortunate because it is more relevant to the health of children than to other age groups. With the rapid growth of brain and body which occurs in the early years of life, and with each stage of mental and physical development having its own time and place in that process, children (specially those from impoverished families) cannot afford to fall ill and be treated only to fall ill again. Our common task is to hasten the process of gearing medical education and health services to their support.

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BEING HELPFUL TO CHILDREN

Statement by David P Haxton
UNICEF Regional Director for South Central Asia

Children have only lately begun to be one of the substantive concerns of development planning. And it may be some time before they become the main priority among competing demands on national and global resources of many kinds : food, technology, money, communication and, above all, the awareness and will to know and to act for changing the human condition. For its part, and in progressive fulfilment of its mandate from the General Assembly, the United Nations Children's Fund would like to hasten the acceptance, in practice, by peoples and their governments of the truth that development begins with children. Toward this end we welcome serious public discussion of the situation of children and an open and continuing debate to influence public opinion. The State of the World's Children report of 1984, like those of previous years, is primarily intended to stimulate discussion and debate, policy and action in particular national contexts. It is good to see the process picking up pace.

Obviously, there are two opinions on the means to change the situation of children, which is unacceptable by any standard—infant mortality, childhood morbidity and subnormal development.

A strongly held view sees structural impediments in the social order coming squarely in the way of any lasting situational improvement. Another argument puts economic growth as a precondition for development of children. UNICEF recognizes, and has repeatedly gone on record, that changes in the structure of a society (reflected, for example in land ownership and employment opportunities) as well as a reasonable rate of growth of a national economy (currently under extra strain from global recession) are necessary to assure proper development of the human resource. Our message is that it is inconceivable that children should wait upon either to happen for meeting the immediate needs for their healthy growth. All the more so at a time when neither economic development nor social change is moving rapidly ahead.

The perceptions of UNICEF, gathered over the years of co-operation with over 100 countries, are nothing if not experiential. The essence of this experience is that basic services (in nutrition, health and education) can be organized for children from poor families, in advance of an improvement in the poverty situation itself. This effort at social organization, on behalf of children, is the function primarily of awakening and awareness of the community itself—acting with the support of voluntary social workers, enlightened educators and conscientious community health workers. The strength of these categories is presently smaller than demanded by the needs and numbers of the poor; but one of the most hopeful signs of the day is that it is increasing. And simultaneously the consciousness and confidence of the poor is growing on the one hand, and governments, irrespective of ideological persuasion, find themselves impelled to respond.

In communities where basic services for children, including the sources of nutrition, have been established, infant mortality rates have come down; the motivation for more births to insure against likely deaths has weakened; communicable diseases have been controlled; levels of literacy have risen. In short, the hold of poverty itself has loosened—making basic services for children an important and durable plank of an anti-poverty programme.

It is a function of UNICEF to encourage initiatives in this direction and also to disseminate the knowledge of successful examples in many countries—as the latest report on the State of the World's

Children does. To multiply these breakthroughs on a national scale is a developmental challenge, which remains to be met. Whether it can be met—and how—is the paramount concern of UNICEF in all the countries where it cooperates.

UNICEF does not determine or execute programmes for children; this is a function of the government and people of each sovereign nation. What it does is to advocate—on the strength of its working experience—policies and strategies appropriate to the development of the very young; to focus on matters for priority action; to forge linkages between one basic service and another and among disciplines, functions, organizations and citizen groups; and finally, to assist, within the limits of its modest resources, those aspects of development which might not receive timely emphasis but for such assistance. Naturally, the action plans of UNICEF dovetail with the programmes of governments and, with their approval, with the work of non-government organizations.

In many developing countries, most children are caught in a continuing, poverty-induced emergency imperilling their survival, nutrition, health and development. Certain priorities are necessarily established, within the "basic services strategy" to meet the situation. They may not be the same for any two communities. For example, combating anaemia which affects about half the child population in countries of South Asia is an evident priority. So too is iodine deficiency, leading to goitre or worse, which is estimated to have spread, due to environmental and dietary causes, to anywhere upto 200 million people in India alone. Both must and can be overcome by relatively simple, affordable and effective means like fortifying common salt with iron and iodine. Iron fortification of salt is a breakthrough in technology which Indian scientists have accomplished.

Certain other priorities seem to be common for most developing countries, arising from the enormity of the numbers of children at risk; which, in turn, has been traced to the dreadful link between malnutrition and infection. In any community—rich or poor—the best food for an infant is its mother's milk. There are some myths about ability and availability which scientific studies have not yet diminished. For example, not many know that it has been scientifically established that even malnourished mothers have a natural

capacity to lactate. This is of course not to suggest that nutrition for expectant and lactating mothers is less of a priority. What is needed is to ensure—through regulatory, educational and supportive means—that nothing comes in the way of a child's natural right to its mother's milk. Similarly, the most important single check on a child's normal healthy growth is its regular gain in weight. It is not argued that monitoring will assure growth, but in its absence, neither mother nor health worker, may notice growth faltering in time to arrest and reverse it relatively easily. It is therefore an elementary function of the community health system to make weight measurement possible for children in addition to whatever else it may provide. Likewise, the best treatment for a child at risk of dehydration is the early administration of oral rehydration therapy, which is within the means of all families, as experience in Bangladesh and India shows. And, the best protection against six of the most dangerous diseases of childhood is complete immunization during the first year of life. There is no technological or financial reason for a country not to achieve universal immunization within the next few years, irrespective of the status of current coverage.

These and similar protective priorities in child health hold together, promote each other and support nutritional improvement. Indeed, mother's milk and oral rehydration are themselves major answers to malnutrition. It would be misleading to argue that, once these priorities are perceived, some should get precedence over the others. If the development experience of UNICEF holds a lesson, it is that services for children must operate together for any of them to have durable value; and for their total impact to be more than the sum of their separate effects.

Would it be a tall order to expect the relatively simple child health priorities to be put into practice ? Not if governments decide to use the opportunity offered by a set of propitious circumstances: the steady spread of literacy including literacy among women; ready availability of simple technologies; and finally the unfolding means of communication for disseminating relevant knowledge. Not if the media, religious institutions, voluntary organizations, public and private enterprises, and the health and related professions decide to regard child health priorities as social priorities

and do what they can to extend this unprecedented opportunity to the poor.

The role of UNICEF is to advocate what can be done. We are encouraged in that many countries are actually doing, often on their own, what is advocated. This effort outgrows the traditional "delivery systems" in health and related fields. Alternative channels are being discovered or improvised. New allies are joining forces in the cause of children. Despite the general international climate of tightening funds, voluntary contributions to UNICEF from governments and private sources are increasing.

The results for children so far may not be spectacular on a social scale, but the trend is clear and the time to strengthen it is now.

(This appeared as an article in the Indian Express of 19 January 1984).

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WORKING WITH THE COMMUNITY

Address by David P Haxton
UNICEF Regional Director for South Central Asia
at the meeting of Rotarians in Calcutta
4 February 1984

It is, as always, a pleasure to be among Rotarians. To join you in the common quest of a community in which no child or adult suffers from want, is an opportunity which we in UNICEF would not like to miss. It will be my endeavour this afternoon to persuade you that this perennial aspiration is attainable in our time.

I have had occasion to enquire of usually well-informed persons what they thought was the biggest threat today that people faced in common. I am sure you can easily guess the replies :

—the extinction of the human race and of all life on this planet as a result of a nuclear holocaust ;

—the ecological disaster due to the steady degradation of the natural environment upon which an increasing population depends for life ;

—the spread of degenerative and psychological diseases, almost on an epidemic scale ;

—the diminishing economic base of life due to depletion of energy sources, inflation, under-employment and unemployment.

All these are real. Each of them has a serious and obvious import for our and our children's future. But our discussion today focuses on another, and no less important challenge facing us all. This is the daily depletion and degradation of the human resource in quality and quantity. Your decision to translate your concern over this human problem into community action for health, nutrition and education is not only welcome but is also likely to succeed. For the first time in history, there is a distinct possibility of achieving universal access to essential food, primary health and basic education. We have the means, if we can summon the will to turn a possibility into reality. These means are provided by the unprecedented availability of simple but relevant technologies, combined with a variety of effective channels of social communication and, more importantly increasing awareness of people in poverty of the possibility of changing their condition. Government's role in this process is clear, but the involvement of all channels of support and service is called for. For its part the Rotary has a unique opportunity to participate in their own way in social action. It is in this perspective that I shall try to identify certain basic *principles* of working with the community, some practical *strategies* that may be useful in such work and a few *priorities* in terms of time and the urgency of needs within the community.

Before I discuss principles, strategies and priorities of working with the community, let me make a couple of preliminary comments. Our motive for promoting basic services in communities which lack them is altruistic and because we believe it to be right. However there are other reasons which should motivate all of us. The poor already outnumber the non-poor and are, at present pace, set to increase their proportion. If they are not enabled to feed themselves and be educated and healthy, the consequences for the shrinking non-poor minority would be extremely grave—for, an

island of well-being can no longer be sustained in the midst of privation.

My second observation that the present situation, however bad, need not spell gloom. I am not only anticipating the use of new technologies and social systems for applying them, but also recalling the substantial, though insufficient, progress already registered in terms of social indicators. The credit for this must go partly to government policies and structures and partly to the excellent examples of dedicated effort by voluntary workers in isolated pockets scattered through this part of the world.

I would in this connection like to mention, in relation to India, some indices of progress in recent years. For example, the infant mortality rate has come down from 140 in 1975 to 126 in 1978 and, according to the latest official computation to 114 in 1980. In this light I would say that the goal of 60 or less by the turn of the century is not impossible. Similarly, the literacy rate has risen, however slowly, from over 29 percent in 1971 to more than 36 percent in 1981. Female literacy is still unacceptably low at less than 25 percent, but this is some achievement compared to less than 8 percent in 1951 and less than one percent in 1901. That this pace can be quickened in our own time is clear from the case of Kerala where female literacy rate is 65 percent.

As I shall explain a little later, immunization of all children in the first year against the six common diseases is a social priority. The present coverage in India is insufficient to break the chain of disease transmission, but what is significant is the positive trend sharply reflected in the past two years. The coverage for DPT was 29 percent of the relevant age group, it rose to 38 percent in 1982-83, which lends hope that 70 percent by 1985 should be possible. The coverage of polio vaccine was only 9 percent in 1981-82, but 17 percent the next year and so the target of 40 percent by mid-eighties is not unrealistic, even though still low. To give another example, there were, in 1980 over 230,000 villages without access to safe drinking -water. In the three subsequent years more than 98,000 villages have been provided with some clean drinking water. If all those in and outside government who have a contribution to make to this process of change, try hard enough, the national goals set for this decade and the next can be achieved.

I would suggest that your plans for community level work be seen against this background of necessary ambition and realistic hope.

I would propose that the first principle of community work is that development begins with children. This is only beginning to be accepted by development planners, but is widely acted upon by successful voluntary workers. All too often, our concern for children seldom extends beyond our own family. My plea is that we should develop an umbrella of social concern and action that will shelter *all* children.

The two decades of development may not have produced results enough to subdue the rate of population growth, yet their yield is significant in that the consequences of poverty have been successfully contained in particular geographic areas. Such changes have occurred dramatically in relation to children and ahead of basic changes in the social-economic structures; which too are bound to become more equitable once the grip of poverty loosens. If we look closely at this positive experience, it is seen that the traditional concept of *welfare* (providing material assistance to people in distress) has to give way to the more dynamic concept of *development*. Four elements can be identified in this process: *growth, well-being, equity and participation.* All of these must guide any worthwhile work with the community.

Another aspect relevant to our aim is the *preventive* principle. The poor cannot afford to fall ill, to get treated, only to fall ill again. Curative health services developed for the well-to-do are largely inappropriate to the poor. The preventive approach saves not only health but also time, money and agony.

Community work must concentrate fairly precisely on pockets of poverty and ignorance rather than be diffused over a wide range of good things to do.

And in a climate of scarce public resources, there is no alternative to enhancing the capacity of the family to feed itself—albeit through modest incomes generated from skills acquired and applied by women as well as men. This process will take time and, in the meanwhile, it is necessary for the State and voluntary

groups to intervene in the market on behalf of those without the power to enter it. Food or other subsidies are to be seen in this perspective as public or social support to the development process, rather than as gestures unconnected with it.

Among the principles that might guide community work, I might add that help must first go to the neediest; that only group action can neutralize for one another's limitations; that the use of local resources prominently implies the use of local *ideas*. No two situations are alike, which means that whatever the approach, it must allow for local variations to meet actual needs.

Development promoters or agents have to remember that the lead role belongs to the *people*, not to themselves. When it comes to development of children, the lead role goes to mothers and fathers. We can draw a useful lesson from the memorable words of Mahatma Gandhi : "There go my people, and I must follow, for I am their leader."

We in UNICEF have tried to reflect these principles into a strategy for action which I would commend for your consideration. We call it the "Basic Services Strategy." It received the approval of the UN General Assembly in 1976. I would like to mention its salient points :

The basic needs of children are known—safe water, nutritious food, primary health care, clean environment, basic education. These in turn need maternal as well as child care, local production, storage and consumption of more and better quality foods, education of the mother, simple technologies to lighten her daily tasks, and so on. It is our understanding that services of this kind for a community cannot be generated from outside on a viable basis. They can be established and maintained durably and on the required scale only if the community wills to have, and works to keep going, these mutually supportive services.

Certain implications of the Strategy follow :

—first, active involvement to the maximum possibility of men and women of the community in planning, establishing and maintaining the services ;

— second, the use of trained local men and women, part or full time, chosen by the community to work these ;

—third, the use of the needed number of auxiliary staff with substantial responsibilities together with the local workers, would make it possible for professionally qualified personnel to concentrate on more specialized roles as trainers, facilitators and advisers ;

—fourth, the application of technology appropriate to the local social, cultural and economic conditions; and

—fifth, contributions in cash, kind, labour and other services from the community to start and sustain basic services.

At the beginning of my address, I drew attention to the socially unacceptable condition of a large segment of the population. And I said that it is within our means to brighten them. In this task, certain priorities are necessarily established, within the "basic services strategy." These are dictated by the specific conditions presently obtaining in the country. For example, anaemia and iodine deficiency, both of which are common, can be combated by the relatively simple, tried and tested method of fortifying common salt with iron and iodine.

Certain other priorities follow from the numbers of children at risk; which, in turn, has been traced to the link between malnutrition and infection. In any community—rich or poor—the best food for an infant is its mother's milk. Even malnourished mothers have a natural capacity to lactate. This is of course not to suggest that nutrition for expectant and lactating mothers is less of a priority. What is needed is to ensure—through regulatory, educational and supportive means—that nothing comes in the way of a child's natural right to its mother's milk.

Similarly, the most important single check on a child's normal healthy growth is its regular gain in weight and height. It is not argued that monitoring will assure growth, but in its absence, neither mother nor health worker, may notice growth faltering in time to arrest and reverse it relatively easily. It is therefore

an elementary function of any community health system to make growth measurement possible for children in addition to whatever else it may provide.

Likewise, the best treatment for the thousands of children at daily risk of dehydration is the early administration of oral rehydration therapy. A mixture of salt and sugar in water in right proportions, it is within the means of all families, as experience in Bangladesh and India shows.

And, the best protection against six of the most dangerous diseases of childhood is complete immunization during the first year of life. About a million children succumb to these diseases each year in India.

There is no technological or financial reason for any country not to achieve universal immunization within the next few years, irrespective of the status of current coverage. These and similar protective priorities in child health hold together, promote each other and support nutritional improvement. Indeed, mother's milk and oral rehydration are themselves major answers to malnutrition.

I now come to the question of what Rotarians can do for children in the context described by me. In making a few suggestions I keep in mind the multi-disciplinary talent that the Rotary brings to bear on the community; for development of children demands a multi-disciplinary approach. I am also aware of the tremendous capacity you collectively enjoy to influence decision making in a plural society—by virtue of the different and distinguished positions you hold as individuals.

To mention a few of the many possibilities, the Rotary could take an interest in and actively participate in the government-sponsored ICDS (Integrated Child Development Services) which are fanning out into all parts of the country and will soon be covering a fifth of the 5000 odd development blocks in India. Modalities of such involvement can, I believe, be worked out but, depending on the circumstances, it could cover funding, training support or mobilizing of resources. You will agree that a direct channelling of resources will be more cost-effective than paying taxes to pay

for ICDS I For the priorities I mentioned earlier and for establishing the basic services into which they fit, ICDS provides an excellent opportunity.

There are other, concurrent ways of promoting these priorities. In your own organization—be it an office or factory or whatever : how well are the children of the employees protected against malnutrition and infection? Are all of them immunized? What can be done to ensure that babies receive the full potential of their mother's milk? Is their growth monitored regularly? How can you ensure that all the employees, and their families are protected against deficiencies of iron, iodine and other essential nutrients thereby enhancing their productivity as well as health. There is no training in community work like the experience of working with your immediate neighbourhood I

UNICEF would be delighted to send you technical and experiential literature on most of the points I have stressed today. We can share with you reports on successful examples of work at the community level, many of which appear in FUTURE : the development journal UNICEF publishes with focus on the children of South Asia. We would be happy to assist in other ways we can.

Would it be a tall order to expect the relatively simple child health priorities to be put into practice? Not if governments decide to use the opportunity offered by a set of propitious circumstances : the steady spread of literacy including literacy among women; ready availability of simple technologies; and finally the unfolding means of communication for disseminating relevant knowledge. In fact, governments are giving increasing attention to hitherto neglected aspects of community well-being. For example, one of the States of India has budgeted over Rs. 20 million for rural sanitation, compared to practically nothing in previous years. Public investments in the social sector are increasing. The present task is to maintain this tempo, mobilize all channels of resources, and to ensure that the investments yield intended and timely results. This is the hopeful context in which the media, religious institutions, public and private enterprises, the health and related professions, and voluntary organizations like the Rotary, will be well-advised to regard child health priorities

as social priorities and do what they can to extend to the poor this unprecedented opportunity for self development.

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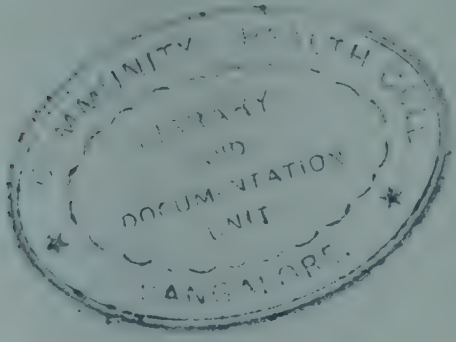

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NUTRITION AND GROWTH MONITORING

Statement by Alexander C. Tosh, Principal Officer
UNICEF Regional Office for South Central Asia
at the Workshop on "Better Child Nutrition in J&K"
Srinagar, 4-6 April 1984

The declared purposes of this workshop are to study child nutrition in Jammu & Kashmir and to review existing technology for data collection and monitoring. In the harsh world outside the workshop the concern for child nutrition and health has to be met by ensuring that children have sufficient food, by protecting them against debilitating infection and illness and by raising individual, family and public awareness and knowledge about nutrition, about malnutrition, its causes and remedies. Of these three measures, the last is the most important, if only to remove the misconceptions and misunderstandings which surround the subject.

Some of these fallacies are mentioned in "The State of the World's Children 1984": "that malnutrition is caused by lack of food and particularly lack of protein. Yet in perhaps half of all cases of child malnutrition, infection is the prime cause. Measles, whooping cough, TB and diarrhoea along with fevers, respiratory infections and internal parasites can all contribute." In India, the Registrar General in his Survey of Infant and Child Mortality has identified the ten most active killers and causes of morbidity in children as tetanus, prematurity, pneumonia, other respiratory disorders, influenza, dysentery, typhoid, malaria, diarrhoea and bronchitis. Half of the infant deaths occur in the first month of

life half of those in the first week. The infants at highest risk are those of low birth weight, whose mothers are undernourished, themselves of low weight, and, of course, unprotected against tetanus. Even where adequate food is available, millions of children are malnourished because they simply cannot consume sufficient quantity of the bulky gruel or pap with which they are fed. It is estimated that in J&K three out of four children suffer from nutritional anaemia. Goitre is not uncommon. So, to repeat: the educational background to nutrition is essential to any of the measures necessary for its full understanding and control and for lowering rates of mortality and morbidity.

Growth charts are the most widely used educational tools associated with nutrition. They are designed to make malnutrition visible to the health worker and others in the home who can understand the symbolism and meaning of the charts and to promote discussion of child health and nutrition between health workers and mothers. Like all educational technologies they must be designed in light of the capacity of the users to employ them to good effect. And, if necessary, the intellectual capacity of the users has to be enhanced by intensive training. These are not simple matters—as will be revealed by a look into the development of growth monitoring over the years, and into contemporary differences of opinion on the state of the art.

In the past fifteen years, growth charts have been studied intensively by experts all over the world. WHO, in particular, have sought a standardized system for recording and interpreting, data, both for service and research use.

Since 1971, when the FAO/WHO/UNICEF Protein Advisory Group agreed that the use of external standards is acceptable in situations where local data are not available, there has been an escalation in the number and diversity of recording methods. When a global survey of growth charts was made a few years ago, it was found that 73 per cent were based on weight-for-age measurements, although 27 per cent also included height-for-age; differentiation was made between males and females in 56 per cent; 44 per cent used standards derived from other populations; 55 per cent applied percentage classifications of deficit (such as those proposed by Gomez and Jelliffe). There were many other differen-

tiating features and, in addition, charts were found to be used variously as immunization records, for dietary information, to show developmental milestones, to record head circumferences, as records of minor ailments, for family planning instructions, etc. Overall, the survey revealed a preference for weight-for-age measurements recorded separately for each sex and external standards were found to be widely used; classification was generally in terms of percentage lines; there was an evident priority for additional information on immunization and diet.

In very recent times, what was the accepted wisdom of the seventies on growth has in turn been challenged, with increasing attention being given to factors which have become known as adaptability, seasonality and "catch-up". The debate about "norms" and the acceptability of external standards has intensified. Alternative technologies have been developed. For example, one recently designed chart consists of a plastic tape for measuring upper arm circumference on which a simple cursor locates a dot entered onto the chart. It calls for no literacy and is very low-cost.

When to the vast array of alternative theory and diversified practice are added the inevitable subtle differentiations between languages and cultures it becomes increasingly unlikely that a "standard" growth chart does or can exist. It is essential, therefore, that each community of users has to carefully scrutinize its objectives and needs, and to design or choose the instrument best suited and appropriate to the particular circumstances. The design may be original or an adaptation from another which has been tried and tested elsewhere. The Tropical Child Health Unit of the Institute of Child Health in London has a collection of 280 weight-for-age charts, 112 of which were designed in Asia. Obviously there is room for a great deal of individuality in growth chart design although there would be overwhelming advantages in having a common growth chart design which would render data comparison, analysis and interpretation possible across different situations and geographic locations.

The objective of a growth chart is to promote healthy growth by increasing the level of awareness and knowledge of the family and the health worker, through a graphic presentation of simple body measurements. Four sets of people are involved with the

design and use of growth charts: the designers, health workers at all levels, keepers and analysts of records, and parents. Each of these groups has different interests and responsibilities which have to be co-ordinated in the final outcome. In order that this should be so, all four groups should be able, in some way, to influence planning, policy-making, design and choice.

The Design

Designers of growth charts have an abundance of background professional and specialist research and experience on which to draw. Charts have been designed by researchers in medical colleges and research institutes—by paediatricians anthropometrists, biometricians, nutritionists and child health specialists. Amongst them, opinions are exchanged and argued about matters such as skeletal maturity, bone age, norms, standards, height, length, etc. Very different, even diametrically opposite opinions exist on these matters. There are advocates of length measurement in preference to height measurement, and those who prefer height to weight measurement as indicators. There are the conflicting opinions on external standards and their validity, on critical periods of growth, on "catch-up" and adaptability. The serious designer must be aware of the arguments and make informed decisions in light of the particular objectives being pursued. For example, he will encounter arguments such as the following: "Weight-for-age is the most sensitive method for identifying those with nutrition and health problems" says Dr David Morley of the Institute of Child Health, London; "The rate of growth of a child is a remarkably good indication of the child's state of health, indeed probably the best single monitor of health that we have. This applies to growth in height, and not in weight....." says Prof. J.M. Tanner of the same Institute.

Growth is a product of the continuous and complex interaction of heredity and environment. The "plan" of possible growth is laid down in the genes; whether it comes to fruition depends upon the environment providing precisely what is called for in the plan at each successive stage of development. These successive stages are *critical* or *sensitive* periods. These sensitive periods occur during foetal growth as well as after birth. Perhaps they differ in different individuals. Opinions vary. The only point of consensus is

that absence of the conditions necessary to these periods *can* cause permanent deprivation or deficiency. However, much evidence exists that all young children have an inborn capacity to recover lost ground after periods of starvation or deprivation of intellectual stimuli. "Catch-up" is possible—within limits. It is not known exactly what these limits are and it would be unethical to attempt to define them by experimental research. The only safe generalization is perhaps that the earlier the deprivation and the longer it persists the less the chance of "catch-up," even in optimal circumstances.

This "catch-up" capacity explains, in part, the human ability to "adapt" to different levels of nutritional intake without loss of efficiency or deterioration in health. The "adaptation" may be seasonal or longer term so that, throughout the ages, the human race has been able (when circumstances have demanded sacrifice) to function successfully on different levels of nutritional intake. Equilibrium can be established at various levels of food intake—up to a point! This point will vary from individual to individual. However, modern researchers while confident of this theory for adults are not yet prepared to assert its applicability to children. Nevertheless, the theory of adaptability challenges the establishment of norms for populations and the classic definitions of undernutrition and malnutrition. In the wrong hands, however, the theory can be misused to support specious agruments about definitions of poverty and levels of deprivation.

Users : the health worker

The term "health worker" is used by WHO to cover all medical and auxiliary personnel engaged in preventive or curative activities. Health workers comprise one category of users of growth charts. In the context of this present workshop the health workers are PHC doctors, auxiliary nurse midwives, MCH assistants and so on—those who are to be involved in the monitoring of child growth in clinics, anganwadis, etc. It should not be assumed that any or all of these will readily understand the growth chart. A recent study undertaken by the Lady Irwin College, Delhi, confirmed that there is a greater understanding amongst those who have progressed higher in the school system than in illiterates or early drop-outs from the system. The range of mean scores obtained in a 22-point test was from 18.2 amongst those who had completed class

10 to 2.5 amongst illiterate mothers. It is clear, therefore, that, for example, anganwadi workers' understanding of growth charts is much higher than that of illiterate parents. However, one cannot extrapolate from that result that the level of understanding necessarily continues to rise at the highest levels of academic achievement. The same study revealed that the mean score (amongst an admittedly small sample) of medical professionals was 13.89—well below the mean score of the anganwadi workers.

The conclusion of the Lady Irwin College study states that "the accurate use of growth charts is contingent upon formal education and training/experience which includes specific instruction on the use of graphs. Also where the educational levels of the field level workers is below class 8 the utility of growth charts is doubtful." This same conclusion has been reached in other countries where literacy rates are low.

Tremlett, Lovel and Morley in a 1983 article on the same subject concluded that "growth charts are difficult to use, even for medical professionals, therefore, caution should be exercised in their use. These charts should be as simple as possible and there should be a training programme prior to their use."

It is not surprising that the conceptualization of a baby's weight as a point fixed in space with reference to two rectilineal axes is found to be difficult. After all, it is an advanced and rather sophisticated mathematical concept introduced as late as the seventeenth century by Rene Descartes—one which revolutionized mathematics and led to the development of the differential calculus. Abstraction of this high order is possible only in those who have attained the Piagetan level of logical operations in their intellectual development. For the most part, therefore, it is necessary for the introduction of growth charts to health workers at all levels to be preceded by intensive training in their use. They must be aware of the potential and the limitations of the chart and be familiar with the alternatives and the arguments supporting them.

Users : Record keepers

All that has been said about health workers is true also, to some degree, of the record keepers, who are the third category of

people involved with growth charts. Intensive training is a *sine qua non*. It seems likely that at least during a period of growth card introduction, record keepers will have to maintain duplicate cards and analyze their contents systematically.

Users : Parents

The fourth category of users are parents. Like the other users they too will use the growth charts beneficially only when they have reached a reasonably satisfactory level of comprehension. Additionally, they will have to see the growth chart in the perspective of other measures by which parental skills can be up-graded to meet the need of survival, protection and care of young children. Monitoring growth by itself can be a frustrating and often futile exercise. Unless the child is immunized against the six major diseases of childhood, is nourished properly in infancy, is given the appropriate therapy when stricken by diarrhoeal disease, is nurtured, cherished and intellectually stimulated in a secure environment —growth monitoring will be insufficient. Physical growth is only one factor in child development. Equally important are the processes of psychological, emotional and spiritual evolution and eventual maturation. These are most likely to develop satisfactorily in small families which are socially and economically secure and in which opportunities for learning and self-expression are readily available. And obviously they will result from the raising of *all-round* awareness, especially of family planning, of levels of literacy and of the other demands of balanced child development.

In this paper some of the controversies and difficulties which surround the use of growth charts have been mentioned. The purpose has not been to confuse or discourage but to suggest that the design and use of growth charts calls for serious thought and careful planning. And preoccupation with growth charts, important though they may be, must not be permitted to obscure that significant factor in reducing infant mortality—protection in *utero* and in the first week of life by sound ante-natal care, adequate nutrition of the mother and correct nourishing of the newborn.

My repeated theme has been the raising of levels of understanding. It is a recurrent theme also of the paper to be presented by Drs. Mattoo and Ali. It is to be hoped that this workshop will

contribute significantly to that understanding amongst all those present and to an eventual raising of awareness amongst health workers and parents throughout the State.

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CHILDREN
IN RURAL DEVELOPMENT

Address by David P Haxton
UNICEF Regional Director for South Central Asia
at the International Rural Development Exposition
in New Delhi, 7 February 1984

I appreciate your concern for children in relation to rural development. And I value this opportunity to expose myself to the wealth of varied development experiences and insights from many communities and countries brought together by the distinguished delegates gathered here.

UNICEF has an abiding interest in accelerating rural development, for some simple reasons :

—the majority of children, and therefore the majority of children in need, live, or struggle to live, in villages ;

—second, the child cannot be developed as an individual independent of the family and of the wider context of the social environment provided the community ; and

—third, basic services for children, like nutrition, water, health care, sanitation and mental stimulation cannot be sustained

except in a community on the move: towards increasing rural employment; higher productivity of small farmers and other rural workers; full participation of all the rural people in the development process; equitable distribution of the benefits of development; and meeting the basic material and non-material needs of the poor. All of these are, I am aware, integral to your vision of rural development.

With these preliminary remarks, I would like, this evening, to focus on that facet of rural development which relates to children. I shall attempt to do this by raising certain child-related issues fundamental to our common future; and by trying to suggest how these may be resolved through a programmatic consensus for action.

It is inexplicable that adult men do not take children seriously enough. The evidence of this irony is the fact that the young child has hardly ever been a concern of development planning in developing countries. School-age children, (a good number of them at any rate), figure on the planners' horizon as a potential resource, a *future* factor of production. And, besides there is a political pressure for more schools and teachers.

Even in a growth-oriented development strategy, the child below six years suffers relative neglect. If equity were a central aim of development, the need to enrich the *present* life of the young child, would have been a major concern. In which case, human resource development would have received attention as a universal goal, helping in turn the aim of growth itself. In such a view there is no dichotomy between economic and social development. This indeed is the lesson learned the hard way over two decades or more, and incorporated in the "international development strategy for the third UN development decade." Equitable growth implies that social and economic development pull together in support of the human being. There is no stage in life when such support is more needed and more useful than in *early childhood*.

What is happening today to young children? In many developing societies, a large number of them, may be a third or more, are born with less than the minimum weight (of 2500 grams) that would permit them to develop steadily. A sizable number of them, one

or more in ten, die within the first twelve months, a large proportion of these in the first few days. Not all those who survive are in health. Under-nutrition and infection are so wide-spread that, in this part of the world, about half the children below six years, as well as pregnant mothers, are assessed to be anaemic, from iron deficiency. In one of the districts of the Gangetic belt, usually considered a fertile tract, four per cent of all newborns are cretins, due to hypothyroidism traceable to environmental iodine deficiency. Anywhere between 150 and 200 million people in India are exposed to this disease, the consequences of which range from lethargy and low productivity on the one hand to mental retardation and cretinism on the other. This problem extends beyond India to Nepal, Bhutan and to one degree or another to other Asian countries.

To give another instance of the current situation, some 1.5 million children die in India every year as a consequence of an easily curable, common childhood episode like diarrhoea. Another quarter of a million lose out in the struggle against measles complicated by pre-existing malnourishment. The upshot of these and similar conditions of child life in a country like India, is that of the 23 million children born in 1983, only a seventh stood a fair chance of healthy development. The situation is all too similar in many countries represented here, only the numbers change, hardly ever the percentage !

The purpose of my narrating this story is to remind ourselves that its scene of occurrence is mainly the rural interior. When you fan out into the countryside in the next few days, you may be visiting those areas where something is being done about the situation, and done with hopeful success, and therefore you may not realize the gravity of the daily depletion and degradation of the young human resource. I would suggest that this situation represents, not a dilemma, but the foremost challenge of rural development.

What is the trend like and is the present condition likely soon to get better or worse ? If we take India, which is in many ways a world in itself, and also typical of the developing world, it is where it is today, after three decades of impressive economic advance and perceptible social progress. The strides on the economic front

are naturally better noticed: near self-sufficiency in foodgrain production, tenth rank in industrial prowess, fourth in scientific manpower, and so on. In fairness, we must also note the appreciable progress, over the past three decades, in the reduction of infant mortality as well as the overall death rate, and the increase in life expectancy and literacy. The task at this point of time, is to sustain and strengthen these reasons for guarded optimism. Clearly, social indicators, have not yet so improved as to indicate a dramatic drop in the birth rate or a socially significant change in the national nutritional status. There are in fact a number of apparent sub-national contradictions like material prosperity co-existing with relatively high infant mortality and female illiteracy. No less incongruous is the low level of infant mortality and female illiteracy in Kerala accompanied by the generally depressed nutritional profile of the population as a whole.

Whichever way we look at the present juncture in any country an autonomous trend towards "better living" is difficult to see. More so in a context of global recession and unemployment, environmental degradation and armaments. It is precisely this challenge that we in UNICEF would propose being turned into an opportunity. In the remaining time given to me, I shall try to outline how the community, at the local, national and global levels, may go about this task.

I am conscious that no two villages or villagers, are alike and I refrain from presenting a common panacea for poverty. Rather, I would like to map a way to development despite present privation.

This approach, as I shall try to show, should weaken the hold of poverty and in time get the better of it—as shown by brave examples scattered in the countryside of nearly all developing countries. Happily, the *principles* of rural development which have been distilled from experience (both positive and negative) square with the *priorities* of child health and development in poor communities. It is my hope that in all the programmes that you will be promoting, there will be an increasing interlocking of these principles and priorities, to the advantage of development in general and children in particular. As I proceed I shall invite your attention to the possibilities of such interlocking.

Current literature is, as we know, replete with inferences as to the main aims of development. These can be identified as *growth*, *well-being*, *equity* and *participation*. These are often confused with programme components which they are not. Rather, they are the criteria by which programme design and outcome are to be judged. Those programmes succeed which combine these aims (as indeed they do, given an opportunity).

"Integration" is a term frequently figuring as a pre-fix to "rural development." This could mean one or more of many things : the bringing together of various programme components, of different programmes, of horizontal and vertical processes, of different organizations, of government and non-government agencies, of people and their environment. I would like to touch as one aspect of it—the implanting of practical ideas on social priorities into each of a wide variety of rural development programmes. Consider, for example, the planning, construction and maintenance of an irrigation project. Integral to the project design and execution, can we appraise its impact in children and turn it to the advantage of their health and development? A way to begin this process is to start with the children of all those working for the project : What are the nutritional and health care facilities available to pregnant and lactating mothers? How practical is it for children to be breast-fed, properly weaned and fully immunized? Can there be a provision for supplementary nutrition, not only in calories and proteins, but also of iron-fortified salt, vitamin A, iodized salt and other needed sources of micro-nutrients? How do we measure how well and fast the children grow? Do we ensure that all children and women have access to learning opportunities relevant to their lives, presently and in the future? Can we promote income-generating activities for women? And on the basis of this cluster of measures, and the employment avenues available directly or indirectly through the project, can we also promote the acceptance of birth spacing? This way we would have laid the foundations of child health and development in and around an irrigation project. And this nucleus could be built upon to reach children and their families in more villages in the neighbourhood.

Programmes specifically for the development of children do not escape the logic of "integration." Those programmes that incorporate all of the elements that answer the needs of survival,

protection and development of young children at risk, generally meet with success. The basic needs of children are known: nutrition during pregnancy and after birth, safe water and a clean environment, primary health care and early learning opportunities. We have tried to interpret the concept of convergent services, even as we co-operate with agencies in and outside government. The convergence is not a final consummation but a coming together of the various services from the earliest stages of, and through the development process. At the level of the community, the nutritionist, the health worker, the sanitarian, the water-supply technician, the pre-school teacher and child development worker have to learn to work together. This has several implications: They need to be trained not only in techniques but even more strongly in their attitudes. They need to be exposed to one another's aims and disciplines. And finally, when there is only one multipurpose worker within the community, she or he will have to imbibe the basics of all the basic services.

It is our understanding that services of this kind for a community cannot be generated from outside on a viable basis. They can be established and maintained durably and on the required scale only if the community wills to have, and works to keep going, these mutually supportive services.

Certain implications of the Strategy follow:

—first, active involvement to the maximum possibility of men and women of the community in planning, establishing and maintaining the services;

—second, the use of trained local men and women, part or full time, chosen by the community to work these;

—third, the use of the needed number of auxiliary staff with substantial responsibilities together with the local workers, would make it possible for professionally qualified personnel to concentrate on more specialized roles as trainers, facilitators and advisers;

—fourth, the application of technology appropriate to the local social, cultural and economic conditions; and

—fifth, contributions in cash, kind, labour and other services from the community to start and sustain basic services.

At the beginning of my address, I drew attention to the socially unacceptable condition of a large segment of the population. And I said that it is within our means to brighten them. In this task, certain priorities are necessarily established, within the "basic services strategy." These are dictated by the specific conditions presently obtaining in the country. For example, anaemia and iodine deficiency, both of which are common, can be combated by the relatively simple, tried and tested method of fortifying common salt with iron and iodine.

Certain other priorities follow from the numbers of children at risk; which, in turn, has been traced to the link between malnutrition and infection. In any community—rich or poor—the best food for an infant is its mother's milk. Even malnourished mothers have a natural capacity to lactate. This is of course not to suggest that nutrition for expectant and lactating mothers is less of a priority. What is needed is to ensure—through regulatory, educational and supportive means—that nothing comes in the way of a child's natural right to its mother's milk. Similarly, the most important single check on a child's normal healthy growth is its regular gain in weight and height. It is not argued that monitoring will assure growth, but in its absence, neither mother nor health worker, may notice growth faltering in time to arrest and reverse it relatively easily. It is therefore an elementary function of any community health system to make growth measurement possible for children in addition to whatever else it may provide. Likewise, the best treatment for the thousands of children at daily risk of dehydration is the early administration of oral rehydration therapy. A mixture of salt and sugar in water in right proportions, it is within the means of all families, as experience in Bangladesh and India shows. And, the best protection against six of the most dangerous diseases of childhood is complete immunization during the first year or life. About a million children succumb to these diseases each year in India. There is no technological or financial reason for a country not to achieve universal immunization within the next few years, irrespective of the status of current coverage. These and similar protective priorities in child health hold together, promote each other and support nutritional improvement. Indeed,

mother's milk and oral rehydration are themselves major answers to malnutrition.

Earlier in this address, I linked the relative neglect of the young child to the lack of equity in development. This applies to comparable extent, to women. I am not suggesting that women could develop in isolation from the family and community, any more than children. In fact the concern for children is congruous with that for mothers and mothers-to-be. For example, experience suggests that a relatively high proportion of literate women is an important factor in relatively low infant mortality. This is the background in which the needs of rural women in maternal health and nutrition, functional education, skills training and addition to the family income are increasingly elements of programmes of UNICEF co-operation in many countries. Our focus falls on simple and inexpensive but technically sound and socially relevant approaches. I shall mention some of the typical among them:

—appropriate technology to lighten the daily labour ;

—better ways of managing existing resources ;

—increasing use of local low-cost sources of nutritive food for infants during the weaning phase as well as for normal adult consumption ;

—breast-feeding of infants for as long as possible ; this costs nothing and is within the physical capacity of mothers from poor families ;

—preventive health care which is simple enough for illiterate women to learn but saves money, time and trouble for the family and the government.

—safe drinking water and cleaner personal, home and village environment come in the same category of conserving health and saving expense in money and energy ;

—community development of fuel lots in the neighbourhood so that the daily search for, and cost of, cooking fuel are cut down ;

—pre-school and child-care centres release the mother for productive, part-time employment while assisting in the child's own development and preparation for life ;

—finally, birth-spacing and family planning help to conserve the resources available to a family and optimise their use.

Before I conclude, I would like to share with you a couple of observations which perhaps coincide with your own development experience.

First, the poor are entitled to the strongest support from the resources of the government. Presently these do not always reach them, even when governments are willing. It is for voluntary organizations to play a crucial bridge-building role. The more voluntary bodies co-operate with the government agencies, and among themselves, the better it would be for the rural poor.

Another aspect is the paramount importance of village level workers. It is their competence and commitment which will make the difference in rural development. They have to come from among the members of the community, rather than from the staff of the government or of the voluntary agencies. Their social background, training, functions and conditions of work need to be determined in a manner that accord fully with the concept and values of rural development.

A third aspect is the question of leadership in the development process. In this third Development Decade, we have, I hope, allowed the people to take the stage. The lead role in rural reconstruction has to be restored to the *villager*. And that in child development to the *mother*. The government administrator, the fund provider, the professional consultant, the development facilitator and the community worker must play a supportive role, not a dominant one.

We are yet to get used to this imperative of development. This is not surprising, because the urge for rural development is a historical response to feudal and colonial exploitation, followed by imitative industrialization and unbridled growth of the city and town at the expense of the village and its wealth—all of which relegated the rural people to the margins of life.

Given this background, how realistic is it to expect poor, unlettered people to play the lead role in their own development? The answer is offered by the promise of collective self-reliance. By pooling their insights, abilities and resources, the group is able to neutralize the limitations and overcome the helplessness of its individual members. For us, the non-rural non-poor, the time has come to believe in the power of the group as *the* dynamic of development.

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—building a base of awareness and knowledge to promote humane public attitudes towards affected persons and their children;

—providing appropriate opportunities and pre-vocational training to prepare the child born of a parent with leprosy, or affected by the disease, for a normal life and the world of work.

Given the unabating magnitude and geographic dispersion of the prevalence of leprosy, our programming is necessarily conditioned by the following approaches :

—the priority falls on those areas where prevalence is high;

—voluntary agencies already active in the field of leprosy control as well as the public health system are extended all possible support;

—leprosy control is integral to the primary health care approach which in turn is built into UNICEF-assisted, area-specific projects.

In consequence there is a growing, mutually supportive relationship between leprosy control on the one hand and basic services to meet basic needs of children and mothers, on the other.

We are keen to refine, strengthen and expand our programmes of co-operation in leprosy control. And we look forward to being helped in this process by your deliberations.

variety of the means of social communication for educating all segments of society, as well as persons at different stages of the disease. We have to carry forward this process of understanding and assurance to the point when the fear of leprosy disappears. *Finally*, we have the medical means to treat and cure leprosy on a large scale and relatively soon. We can prevent, if not the disease itself *as yet*, its physical, psychological and social consequences.

The UNICEF experience of co-operating in leprosy control programmes in several countries around the globe has yielded lessons which I would like to share with you. While drugs dictate the treatment, it is the people who decide the cure. Frustration turns into success when people change their minds and therefore their behaviour. The promise of the multi-drug therapy will be realized only when leprosy control becomes everyone's concern. We are called upon to co-operate with governments as well as non-government organizations to educate all segments of society as well as persons at different stages of disease. We must face the fact that this process of building understanding and changing behaviour is slower, and at times more complex, than providing facilities for sustained treatment.

UNICEF perceives leprosy as a social disability as much as a medical abnormality. In this sense, it is not enough to treat leprosy. The target for treatment is society itself. Luckily this is a hopeful possibility. For we have, through the developing world, a wide reach and variety of the means of communication. All of us, I believe, have to get better at pressing into the service of leprosy control all the available media : folk, print and electronic.

In this perception, we are trying out programme strategies which focus on :

—systematic community level screening; particularly of children, for early signs of leprosy;

—providing drugs and amenities for the alleviation of the problems of affected children and parents;

—support for training of health workers at different levels, and management and monitoring personnel;

FACING UP TO LEPROSY

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
for the WHO Co-ordinating Meeting
on Implementing Multi-Drug Therapy in Leprosy Control
New Delhi, 24 February 1984

UNICEF is aware only too well of the challenge posed by leprosy in these and other parts of the world. We therefore value the initiatives taken by WHO to introduce and implement therapeutic regimens for extensive treatment and relatively rapid cure of the disease. We note with keen interest the ongoing effort to integrate leprosy control programmes with primary health care. That leads us to the basic right and duty of the community to plan and implement leprosy treatment and cure, as part of their health care and in the spirit of Alma Ata.

Nothing so challenges the mandate and work of UNICEF as the social shunning of a child born of a parent with leprosy, or the neglect of a child showing early signs of the disease. But UNICEF is optimistic—on several grounds : *medical*, *social* and *human*.

First, there are with us today vibrant examples of the "fellowship of pain" that moved Father Damien, the conscientious concern that marked Mahatma Gandhi. *Second*, we have also a wide reach and

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New Delhi, 24 February 1984

UNICEF is aware only too well of the challenge posed by leprosy in these and other parts of the world. We therefore value the initiatives taken by WHO to introduce and implement therapeutic regimens for extensive treatment and relatively rapid cure of the disease. We note with keen interest the ongoing effort to integrate leprosy control programmes with primary health care. That leads us to the basic right and duty of the community to plan and implement leprosy treatment and cure, as part of their health care and in the spirit of Alma Ata.

Nothing so challenges the mandate and work of UNICEF as the social shunning of a child born of a parent with leprosy, or the neglect of a child showing early signs of the disease. But UNICEF is optimistic—on several grounds : *medical*, *social* and *human*.

First, there are with us today vibrant examples of the "fellowship of pain" that moved Father Damien, the conscientious concern that marked Mahatma Gandhi. *Second*, we have also a wide reach and

variety of the means of social communication for educating all segments of society, as well as persons at different stages of the disease. We have to carry forward this process of understanding and assurance to the point when the fear of leprosy disappears. *Finally*, we have the medical means to treat and cure leprosy on a large scale and relatively soon. We can prevent, if not the disease itself *as yet*, its physical, psychological and social consequences.

The UNICEF experience of co-operating in leprosy control programmes in several countries around the globe has yielded lessons which I would like to share with you. While drugs dictate the treatment, it is the people who decide the cure. Frustration turns into success when people change their minds and therefore their behaviour. The promise of the multi-drug therapy will be realized only when leprosy control becomes everyone's concern. We are called upon to co-operate with governments as well as non-government organizations to educate all segments of society as well as persons at different stages of disease. We must face the fact that this process of building understanding and changing behaviour is slower, and at times more complex, than providing facilities for sustained treatment.

UNICEF perceives leprosy as a social disability as much as a medical abnormality. In this sense, it is not enough to treat leprosy. The target for treatment is society itself. Luckily this is a hopeful possibility. For we have, through the developing world, a wide reach and variety of the means of communication. All of us, I believe, have to get better at pressing into the service of leprosy control all the available media : folk, print and electronic.

In this perception, we are trying out programme strategies which focus on :

—systematic community level screening; particularly of children, for early signs of leprosy;

—providing drugs and amenities for the alleviation of the problems of affected children and parents;

—support for training of health workers at different levels, and management and monitoring personnel;

—building a base of awareness and knowledge to promote humane public attitudes towards affected persons and their children;

—providing appropriate opportunities and pre-vocational training to prepare the child born of a parent with leprosy, or affected by the disease, for a normal life and the world of work.

Given the unabating magnitude and geographic dispersion of the prevalence of leprosy, our programming is necessarily conditioned by the following approaches :

—the priority falls on those areas where prevalence is high;

—voluntary agencies already active in the field of leprosy control as well as the public health system are extended all possible support;

—leprosy control is integral to the primary health care approach which in turn is built into UNICEF-assisted, area-specific projects.

In consequence there is a growing, mutually supportive relationship between leprosy control on the one hand and basic services to meet basic needs of children and mothers, on the other.

We are keen to refine, strengthen and expand our programmes of co-operation in leprosy control. And we look forward to being helped in this process by your deliberations.

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INFANT FEEDING STRATEGIES

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the National Seminar on Strategies
for Infant Feeding Practices, NIPCCD
New Delhi, 28 March 1984

Some five years ago, the foundations of a world movement for improved infant feeding practices were laid by the joint endeavours of a variety of voluntary organizations, WHO and UNICEF. Today as we seek to discover or refine strategies for accelerating this movement, it is evident that the effort has been through its first phase. In some respects, we are perhaps wiser than in the late Seventies about what it takes to achieve the goal we have set on behalf of children.

The timing of this Seminar, as well as the range of participating professions and group interests represented here, augurs well for a second phase of intensive activity at the community level throughout the country. UNICEF is pleased to continue its close association with every forward step taken in this direction. In keeping with the generally hopeful—though frequently slow—trend thus far, I would like to suggest that this Seminar might like to envision the "state of the art" of infant feeding practices in India five years from now and then search for operational strategies to realize the vision.

Before looking into the future and preparing to promote the process of change, let us briefly review what has been achieved—and what has not been—in the first round of the struggle for better infant feeding practices.

We had, as you will recall, made certain assumptions which are as valid today as when they were made :

—Improper infant feeding practices were *not* a monopoly of economically weak sections of the people, yet there was a close link between infant nutrition and the family's access to food. Malnutrition, morbidity and mortality of infants and children are closely related to poverty in the family. Consequently, more income, better availability of food and proper infant feeding practices often go together.

—All the same, a second assumption remained true and complemented the first : We need not wait till the end of poverty to save the lives and health of children. Improved infant feeding can begin here and now even in a poor family, given an inexpensive, self-reliant and community approach towards secondary and tertiary prevention of malnutrition. The elements of such preventive action are :

—nutritional care through primary health care delivery systems;

—nutrition education at the community as well as professional levels in the fields of health, agriculture and education itself ;

—fortification of foods against common, massive deficiencies of micronutrients like iron, iodine and vitamin A ;

—nutrition surveillance using simple and effective tools of growth monitoring.

Both these premises show that improved infant feeding implies not an isolated thrust but action on a number of fronts. Interestingly, the two assumptions hold together : For example, infant feeding—an obviously emotive issue for the mother and the

family—can intelligently be made to cembine with quick answers to economic hardship, like food security, institutional credit and group solidarity. All of these also imply appropriate regulatory measures under the law and public policy to curb the forces that come in the way of improved infant feeding. The educational thrust has to proceed apace to overcome ignorance and wrong beliefs and to gain confidence and skills.

Seen in this perspective, the past few months and years have yielded some positive results: The international code of marketing of breastmilk substitutes adopted by the World Health Assembly, which remains the frame of reference for concerted action, has received the backing of professional and consumer organizations. Progress on its implementation has been modest but real. Over a hundred nations have started the process of changing hospital practices. Several of them, including India recently, have adopted marketing codes to protect babies from the threat of commercial formula. We do hope that the Indian notification will soon acquire the status of law and the practical attribute of enforceability. In some countries, public advertising of breastmilk substitutes have been banned. In India the ban applies to government radio and television. Some governments have prohibited the distribution of free samples of infant food in maternity centres. In India, instructions have been issued in this respect to government hospitals. Health care systems are slowly being geared in support of breast-feeding and the other principles of the Code. The reshaping of education and training of health workers at all levels—professional, paraprofessional and multipurpose—is being attempted. Each of these lines of action will have to be pursued to its logical fullness.

More encouragingly, consumer forums and voluntary agencies have established networks, as in the case of India:

—to educate mothers on what is good for their babies; and

—to monitor, at the community level, the inroads of commercial interests into the capacity of families to be self-reliant, on the one hand, and the progress in improving infant feeding practices on the other.

There is, in the meantime, a ground-swell of support for natural feeding in practically all the industrialized countries, with babies

being increasingly restored to the breast—after a thoughtless gap of nearly a generation of bottle feeding.

Inevitably, infant food manufacturers seem to be falling slowly in line with professional and public opinion. Here we must, I believe, be clear in our minds on what is defensible and what is not. UNICEF for its part has nothing against a reliable infant food formula or weaning food product, but there is no justification to prompt people, rich or poor, to opt for these when more sensible alternatives are almost always available. The line that divides the legitimate from the exploitative must be clearly drawn.

I need not iterate the decisive arguments for breast-feeding and against bottle feeding—though I would like to urge some measures needed to protect and promote effective breastfeeding on a national scale. I am recounting them not in any particular order of priority but as a cluster each of which it is everyone's responsibility to promote in whatever ways and contexts possible:

—National legislation to protect and promote proper infant feeding has to be complemented by administrative mechanisms, reporting systems and corrective procedures. It is not too early to think and act in these directions.

—A continuous campaign is necessary to inform and educate the mother and the whole family on the value of breast-feeding and proper weaning. This responsibility falls as much on professional and voluntary organizations as on the departments of government.

—A substantial revision of teaching and training curricula is overdue in all educational institutions starting with the primary school and the non-formal systems of learning for children and adults, going on to tertiary education of nutritionists, doctors, health workers, teachers, social workers and government planners.

—There is then the neglected or underestimated requirement of maternal nutrition which underpins the ability of the mother not only to give birth to healthy infants and to provide breast-milk and child care, but also to safeguard her own health and

productivity. The point is that maternal nutrition must begin long before pregnancy—from female childhood and particularly from puberty. And begin at home, with the family pot.

—Closely related to improved infant feeding and interlinked with maternal malnutrition and frequent illness, is the lack of education and social status for women, and the consequent burden of frequent pregnancies and excessive domestic work. An obvious way to redress this situation is to enhance the participation of women in the affairs of the community leading to better working conditions at home or in employment. We must work for a better and more universal acceptance of maternity leave, job security after delivery, facilities for child care and breast-feeding at the workplace and similar other principles of ILO conventions.

—Finally, the entire health system has to be deeply influenced, so that health planning and practice focus on :

—prenatal care and food supplements for malnourished mothers and those at risk ;

—immunization of expectant mothers against tetanus ;

—guidance for mothers and families on the value, management and maintenance of lactation ;

—avoidance of unnecessary drugs or surgery during delivery;

—commencement of breast-feeding soon after birth ;

—avoidance of separation of child from the mother ;

—frequent on-demand breast-feeding ;

—discouraging bottle feeding, except on specific medical instruction ;

—use of contraceptive methods that do not interfere with breast-feeding ;

—postnatal care and advice to mothers ;

—mother's milk for babies unable to breast-feed ; and

—informing mothers about the value of colostrum which many still consider unsuitable to be fed to a newborn.

At this point, I would like to invite your attention to the urgent need for a rational approach to weaning foods. Their role is not to wean the baby away from breastmilk but to supplement it from the time the baby is four to six months old. But there is insufficient knowledge on proper weaning practices: what weaning foods to be given, when, how much and how often.

In most of rural India today, breast-feeding is prolonged as well as universal—but *without* supplementation. It is clear that this late introduction of supplementary food (which in the event happens to be adult food from the family diet), is one of the major factors of malnutrition, morbidity and mortality in late infancy and early childhood.

Like in the case of breast-feeding, proper weaning rests on effort in three directions: *educational, enabling* and *regulatory*. And it involves action again at three levels : *political, professional* and *popular*.

I would therefore enter a strong plea for a clear policy and programme on weaning foods. There is already some progress to a consensus of opinion on this. Its main element is support for production of relatively inexpensive weaning foods at home, at the community level and also on a zonal scale, suitable for different regions and based on local materials and cultural preferences.

Any attempt to promote infant nutrition ought to pay equal attention to arresting, if not preventing, infections in infants. Judged by the extent of prevalence and its assault on health and life itself, diarrhoeal dehydration must be seen as a nutritional problem of social priority. Until we attain the capability of preventing diarrhoea itself through proper nutrition, clear water and safe sanitation, oral rehydration must become a routine response to infant and child diarrhoea—at the time and place it strikes, namely the home.

In all of what I have said, it is essential to sustain strong information and communication support through modern channels as well as through community structures.

Infant nutrition has long suffered because it was conceived too narrowly in scientific as well as social terms. If we take care to move in a co-ordinated way on all the relevant fronts, spreading knowledge through communication and demonstrating social action through successful examples, the chances are that we would carry the second phase of the movement for improved infant feeding practices through its present, crucial second phase.

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FINDING A FAMILY

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the International Seminar
on Child's Basic Right to Family
New Delhi, 29 March 1984

Many of you assembled here have ventured into a field where most development workers hesitate to enter. When the basic social unit that is the family is dismembered, the last vestige of hope for the child tends to disappear. I see this Seminar as a pathfinding attempt to reafirm the role and duty of the community to step in as the extended family. I bring to you the greetings of the UNICEF community around the world and would like to convey our good wishes for a positive outcome of your exchange of ideas and experiences.

The UNICEF participation in this conference has two broad purposes: *First*, we would like to learn how a developmental concern for the destitute child may be woven into our varied programmes of co-operation in differing national and sub-national situations. *Second*, we would like to check with you how far some of our insights from work in fields like disease and disability hold good against destitution.

I was struck by a key question raised in one of the papers circulated for this Seminar. "Does not helping some individual children leave the structural causes of child abandonment totally unaffected." The answer I would like to suggest is that the distinction between social change and humanitarian action is artificial. It is a function of development to deliberately outgrow this dichotomy. In the light of our own experience, we believe it is possible to marry short-term support to the life of the individual child with medium-term services based in the community and long-term social development goals. Obviously we have to get better at this art—in a joint effort on children's behalf.

Fortunately, there is some clarity of the central issues involved and the basic principles that should guide action. The Declaration of the Rights of the Child, adopted by the UN General Assembly in 1959 is an unambiguous statement of societal goals : It affirms the child's right to a name (which is the theme of the Seminar) and to a nationality; to opportunities for normal healthy development in freedom and dignity; adequate nutrition and housing; recreation and medical services; love, understanding and security in the care of the child's own parents; education and equal opportunity to realize his or her full potential; and protection against neglect, cruelty, exploitation and discrimination.

In committing ourselves to these aspirations, it appears necessary to remind ourselves of a few strategic considerations :

—First, it is surprisingly simpler to promote the child-related goals together than to pursue them in isolation. The child needs them all, equally and at the same time, though those of us who work for children are conditioned more by our specialisms and preferences than the needs and potentials of children. I would like to raise here a critical issue and leave it to your considered judgement to find the answer: The number of destitute children is apparently on the increase for reasons that have been fairly well analysed. Would it be feasible to establish at the community level services geared solely to their needs ? Would it be possible to combine attention to children without families with attention to other deprived children, on the strength of common but adaptable facilities ?

—The second question is as familiar as the first in every field of child-related activity, whether it be about the child's survival protection, care or preparation for life. While present prevalence of destitution, disability, disease or other deprivation leaves no option but to reach succour and support to those in distress, is it too early to put "prevention" as the overriding principle ? If development is the priority, can society afford to wait till destitution takes over ?

—A third thought that comes to my mind is on the concept of the *rights* of the child. Clearly we are applying "adult" language to one who has no vote, organization or other means to influence the system. A *right* suggests more than a desirable value and implies the sanction of law and the option of redress in case of violation. I was glad to find among the background papers for this meeting a good discussion of the status of legislation on some aspects of children without families. Legal remedies which today do not seem to fully answer even the issues of "adoption," will have to reach the heart of the problem of destitution.

As I mentioned, a UNICEF policy against child destitution is in the making. And it will evolve as we gain experience in Brazil, in India and elsewhere. However we have the benefit of having some sound social and legal principles relating to the protection and welfare of children. For example, those enunciated on the initiative of the UN Commission for Social Development on foster placement and adoption provide a basis for moving ahead.

Once full development of the child becomes the paramount criterion, restoring the child to the natural family, with needed support, in whatever appropriate form, should be the first concern. Adoption and foster care would be the next alternatives. And the needs of adoptive parents should, in the process of selection, become subsidiary to the interests of adoptable children. Once we realize that institutions for destitute children are unlikely to disappear as long as children get abandoned for whatever reason a sensible course of action would be to relate these institutions in a positive developmental way to the neighbouring community and use them to mediate the process of helping children back to a home—their own or an approximate alternative. On these and

allied issues, UNICEF looks forward to a set of relevant strategies that I am sure will emerge from this Seminar.

Before I conclude my address, I would like to return inevitably to the theme of preventing destitution. The roots of child destitution (with which all of you are familiar) point to a frame-work for action to arrest, and if necessary reverse, the movement from village to town, to promote social and economic development of unemployed, impoverished parents to organize community-based basic services for children.

I would suggest that these broad aims have to be translated into inter-linked programmes of preventive as well as remedial value: income generation; birth spacing; counselling; essential facilities before, at and after birth; proper infant feeding ; immunizing against diseases ; prevention of disability ; precaution against diarrhoeal dehydration ; guidance in health, nutrition and hygiene ; relief in times of crisis ; day care of the young child ; children's homes till return to the natural family or another home is arranged.

Only the combined effect of a converging cluster of basic services can underwrite the development of a child in need. For this to happen, a suitable community structure with a lead role for women has to be established. Voluntary initiative backed as necessary by the resources of the state can achieve this aim. And once an alert and informed ccmmunity structure is in place, it will be relatively easy to protect children against destitution and to prevent children from being pushed out of their families.

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PROGRAMMING PACE AND DIRECTION

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the UNICEF Executive Board
May 1984 Session

I would like in the first part of this brief presentation to touch on the substance of the document already before the Board on 'Programme development' in South Central Asia during 1983. I will then report some of the more important recent developments in the Region. In the third and final part, Bhutan's case for supplementary funding for a cluster of programmes will be outlined.

In South Central Asia, we constantly remind ourselves that UNICEF can make an impact on the lives of children in two ways :

—advocate that certain steps on behalf of children are feasible to be taken here and now despite prevailing poverty ;

—secondly, extend appropriate support to what government departments and non-govornment agencies may decide as feasible and necessary to do; and work together with them as steadfast but junior partners through success and set-backs and renewed effort.

These two dimensions of UNICEF work coexist, and mutually reinforce.

I mention this pattern of co-operation to convey how we have broadly succeeded in all the countries of the Region in breaking new ground in respect of child survival issues like maternal nutrition; pre-natal care; immunization; breast-feeding and proper weaning; prevention of deaths from diarrhoeal dehydration; social response to deficiencies of iron, iodine and vitamin A; and, in conjunction with all these, regular access to a simple tool of nutritional surveillance like growth measurement.

The interventions for child survival can be promoted only through systems supportive of child development in fields like nutrition, health care, family planning, preschool, primary and functional education and communication. These infrastructures exist substantially in the different geographical areas of the Region. The relevant coverage and quality of the services offered by them may be uneven—which is, of course, a matter of abiding concern in the context of the ongoing country programmes of co-operation.

As illustrated by our report for 1983, perhaps the most important development of that year was the acceptance by all the governments in the Region that development of children cannot be the province or preserve of one or two ministries, professions or centralized organizations. We are glad that this perception is steadily leading to:

—broad spectrum public policies in support of children, cutting across conventional sectors;

—an important place for children in national development planning, with priority for their development slowly rising to what is deserved;

—co-ordination at the highest political level of necessarily decentralized development activities on behalf of children.

Our ambition in the Region is to achieve a dynamic fusion of the child survival priorities, the concept of primary health care which is in transition to practice, the slowly expanding cluster of basic services and the generally accepted long-term aims of development. This way child development will be better assured beyond survival;

and UNICEF will have found more allies than ever before. This is precisely the attempt of the country programming exercise for India 1985-89. We are in the middle of it right now and will come to the Board this time next year.

I would like to take this opportunity to share a view of the scope of, and attempts at, advocacy—more so because 'communication,' as a resource of development, is likely to be one of the highlights of co-operation in the coming years in India and in the other countries.

The communication infrastructure in India is one of the largest in the world—even at a low literacy rate of 36 percent. The newspaper circulation is over 50 million in 16 major languages (and 68 other languages and dialects); the radio reaches some 250 million listeners; the television has an audience of more than 20 million. Some 70 million people see films each week.

Theoretically, this network can be used to trigger the urge for self-development of some 600,000 villages. It can be made to nourish traditional forms of interpersonal communications supportive of the quality of life in the villages.

I am glad to report that we have crossed the threshold of this possibility. We have begun to use each of the available channels to focus on child health issues. And we mean to expand this involvement in quantity and variety of both media and message.

This is not to say that we have yet reached the communities in village or slum—much less put communication to participatory use by them. But I believe we are preparing the way for that with the help of both government and non-government channels.

The Regional Report last November was, on balance a document of justified hope. Soon after we sent it, the Government of India adopted a Code of Marketing of Breastmilk Substitutes on the lines of the WHO/UNICEF Code. This is a strategic gain for the Region, where Afghanistan and Sri Lanka adopted national codes a little earlier. The pathfinding recommendations of the National Workshop on Weaning Foods in July 1983 have also received the endorsement of the Government of India. These comprise a variety of complementary approaches : support to adapting family diet to

suit the weaning stage; ready-to-eat and ready-to-mix food distribution; fortified flour through public distribution systems; involvement of women's groups in weaning food production; establishment of plants at district and block levels and educational effort across the social spectrum.

Based on these two policy planks for sound infant feeding practices, we have mounted a massive effort at public information at the community and national levels, at professional information through professional channels and at reshaping teaching and training content from primary schools to medical colleges, from women's groups to agricultural universities. It is possible to report that the first round of the battle against bottle feeding has been won, and the struggle against faulty weaning practices has well and truly begun.

Governments in the Region had never questioned the need and urgency of universal immunization. Indeed, they have had programmes in its pursuit. The recent development is that they have shown renewed confidence in their capacity to achieve it in the measurable future. We believe that UNICEF has contributed in some measure to this new perception. For example, lately UNICEF has been intimately involved in achieving practically universal coverage in respect of DPT, polio and BCG in three areas of India with widely differing natural characteristics and resources : *Bidar*, where the existing health infrastructure was upgraded for the purpose : *Devas*, where the weak public health system was reinforced by mobilizing the resources of the State administration as well as the local community; and suburban *Delhi* where the institutional base of the Integrated Child Development Services (ICDS) scheme was reoriented to achieve full coverage. These experiences have been analysed and documented in a booklet titled : *Immunizing more children.*

We believe universal immunization on a national scale is feasible in the remaining years of this decade. The infrastructure of a national programme of immunization already exists. India has gone universal in limited areas and these provide a spring-board for going both universal and national. The Ministry of Health is showing unprecedented keenness in achieving this goal, which they themselves had set for 1990. For the first time other ministries in the government are taking an interest in what they can do in their own spheres of influence. It is likely that a top level inter-ministerial group

may be involved in the programme. This would be welcome in that complementary approaches, alternative techniques and state and district programmes could coexist for achieving a common aim. The Bellagio Conference in mid-March reaffirms the UNICEF perception that neither finance nor technological support would be found wanting if the governments take the initiative and play their major and decisive part.

As reported, the immunization coverage in Sri Lanka is the highest in the Region and the incidence of immunizable diseases in the country has declined. Moving to scale in immunization as well as in the other child survival priorities is very much in sight. I am glad to report that in the annual UNICEF Programme Review last month at Colombo, as many as nine ministries and a number of international and bilateral agencies participated.

There is a similar pattern at work in Nepal where a large number of organizations from outside the country, including UN agencies, are co-operating with the government in breaking the barrier in the way of universal immunization. I am also glad to report that the joint nutrition support programme in the country has finally begun.

What I have said about immunization is as true in respect of diarrhoeal management. The idea of oral rehydration with ORS packets or home sclutions has been accepted by all the governments, in the face of an annual toll of 1.5 million child lives in the Region—taken by this entirely manageable simple, common childhood infection. But the ground so far covered is insufficient. Some 9 million packets being annually produced, a part of it distributed through government channels including village health guides, are too few. Most private health professionals accept ORT more in theory than in practice. And the message of self-reliant home-based diarrhoea management is yet to reach the millions of helpless mothers. The picture today is certainly more hopeful than a year ago, but once again the pace of advance can be set only by governments, but we are on our way.

The threats to child survival are contained in a complex of factors embedded in the past of the countries of the Region. For the same reason a reduction in the infant mortality rate will be the result of a mix of favourable factors, of which the priorities

proposed by UNICEF are the most important and immediate. The impact of what is being done will take time to show. But the trend is clear whether it is India where infant mortality has come down from 129 in 1970 to an estimated 114 in 1980, or Nepal where the figures are 260 for 1970 and 150 for 1982.

It is in the light of such trends that the countries in the Region have begun to envision the chances of survival and development of a child born at the beginning of the 21st century as twice as better than today. I believe this is no empty dream, *if* the governments and the rest of us are prepared to pay the price to make it come true.

I would like to take this opportunity to mention some salient points in support of the proposal for supplementary funding for Bhutan during 1984-86. This relates to a spectrum of co-operation between the Royal Government and UNICEF across the fields of water and sanitation, primary health care, nutrition and school education. In each of these, His Majesty the King takes a close and personal interest, which is a guarantee that the resources will be absorbed and applied to good effect. The planning and implementation of these projects are already decentralized to the district level. There is no shortage of self-reliance among the people of Bhutan but there is a shortage of trained manpower as well as basic services for children.

Development can be seen to be happening in Bhutan. In spite of the handicap of widely scattered habitations and the disability imposed by massive nutritional deficiencies like iodine, the natural environment is still intact. UNICEF provides a neutral and acceptable access to development assistance for this small land-locked, least developed and most seriously affected country.

Our recent programme of co-operation against iodine deficiency diseases is an excellent example of what is possible in Bhutan. A UNICEF sponsored study in early 1983 revealed an appalling goitre rate of 60 percent for the whole population. A plan of action has since begun, including supplies, equipment, expertise and a tested public awareness-building scheme in support of the aim of using iodinated salt exclusively and throughout the country. It is reasonable to expect that the scourge of iodine deficiency disorders will be rooted out of Bhutan in ten to fifteen years.

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ANOTHER ROAD TO HEALTH

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
at the WHO Consultation on Primary Health Care
(Transition from Vertical to Integrated Programmes)
New Delhi, 4 June 1984

By definition, primary health care moves away from vertical programmes to programmes activated and controlled by the community. The choice of the theme for this consultation is therefore appropriate. And UNICEF is happy to have this opportunity to learn from the experience in overcoming the tensions of this transition to another pathway for the people towards health. I need hardly add that primary health care is a cardinal principle guiding UNICEF policies and programmes of co-operation, at least ever since the concept was articulated clearly and jointly by WHO and UNICEF.

The six years since Alma Ata have been difficult for primary health care, except for isolated examples of successful practice of the idea in fairly limited population groups. We look forward tc discussions in the next few days of the experience of such people-centred efforts, rather than to an intellectual debate between selective and integrated approaches to primary health care. A

debate which may not be as relevant to the people we aim to serve as it may be to ourselves.

As you will recall, the 1970s, especially the latter half, saw an upsurge of developmental ideas—largely as a sensitive response to the indifferent results of the preceding decades. ILO helped to clarify the question of basic needs, UNESCO began to focus on universal education, UNICEF adopted the strategy of basic services and WHO and UNICEF articulated the primary health care idea. Most member Governments of the United Nations have accepted these principles which in fact belong together as part of the theory of democratic development.

I have outlined this background because it throws helpful light in resolving the nine major issues coming up before this consultation. I would not like to go into them at this stage, except to underline the profoundly political implications of primary health care. If these are understood and accepted, the central issues before us will be easier to resolve.

Let me illustrate : vertical programmes may have had something to do with the ethos of the colonial era but they stem mainly from specialized scientific disciplines. These specialisms will continue in relation to particular health problems. But primary health care puts some distance between itself and specialized personnel, sophisticated technology and expensive facilities. Let us remind ourselves that it is based on an active community backed by appropriate techniques and well-trained para-professional development workers. It has been shown that such community development workers could advise on nutrition and water supply, help with hygiene and sanitation advice, organize immunization campaigns, distribute iron folate and vitamin A tablets, handle basic drugs, support diarrhoea management through oral rehydration therapy, conduct anti-malarial and anti-parasitic campaigns, advise on birth spacing and safer child births, deal with local injuries and illness and refer more specialized problems to more specialized people.

In our perception the problem today is that the mass movement which primary health care was expected to trigger is inching slowly, despite an impressive rise in the number of village level health workers, be they called health guides or guards, health

communicators or representatives. I am sure this consultation will come to grips with the reasons for this slowness.

But, here, let me pose some questions for ourselves as we approach these deliberations: Are we worried more about the *structure* of primary health care than the *potential*? Do we worry too much about turf or territory? Why is it these problems seem more serious to us in the "health field" than with others who urge us to "get on with it"? Are we creating a new cadre to create a new turf? Can we "de-mystify" what we are talking about? Why do we insist that others join in *our* defined objectives rather than join in theirs? What is the breakdown of our budgets? Do we *insist* on priority of people and their health? Or on more and more sophistication in the name of the poor? How many of us are prepared to put the people first and our professions as servants? or supporters?

I would close my remarks with a clarification and a suggestion. Primary health care cannot but respond to the immediate health needs of a given population, and, in our view, with priority to the threats facing children. These priority interventions—whether immunization, oral rehydration, distribution of iodinated salt or other fortified foods, sound infant feeding practices, growth monitoring, washing of hands or whatever—cannot be viably organized except on the strength of existing or new basic services in health, sanitation, nutrition and, not the least, education and communication. And these basic services, in turn, have to be rooted in the community—which is just the opposite of vertical programmes.

Perhaps the answer to the so-called dilemma of selective versus integrated approaches can come from a reformed organizational pattern of health and other basic services. You will agree that the need for a strong central political direction and co-ordination is essential to ensure the continuing support of the resources of the Government. Similarly, the back-up facilities of specialized disciplines and services (which I suppose will continue to be vertical in orientation) are essential. But the vertical streams must coalesce at the level of the community, the optimal size of which may be formed by a cluster of villages.

At this level, the administrative responsibility as well as popular accountability may rest with an authority which will integrate not

only the programmes in the field of health but link them organically with other related programmes. It is at this level, fairly close to the people, that specialized programmes cease to be specialized and mesh one with another in a holistic response to actual needs of the people. This is also the level at which the community, the health and other professions and the public administration could combine against ill-health and for development in and beyond the conventional health sector. A pre-condition to integrated programmes is, let us remember, "integrated" workers who can see and move beyond the confines of one chosen professional field.

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FEWER DEATHS, FEWER BIRTHS

Statement by David P Haxton
UNICEF Regional Director for South Central Asia
(Text of the article published in the Indian Express of 22 June 1984 with the caption "The Best Contraceptive")

The first of all the factors that determine the size of a family is the perception of the parents about the ideal number of children they should have. The poorer their circumstance, the more difficult the decision, the greater the need to look beyond the uncertain present into an unknown future.

Family size is the surviving strength in terms of grown up children. How many children are to be born is within the control of even poor parents. But how well they will grow is not. They may not live beyond the first few months or years. The freedom to make an informed choice in planning the family narrows as poverty deepens. There is however no option for the poor, for whom a surplus of fresh human stock is the only tangible capital that can be invoked. This, in outline, is the poignant story of child births trying to catch up with child deaths—a race that results in a steady rise in the number of lives and a parallel decline in the quality of life. Such is the quandary facing millions of families and therefore scores of countries.

Poverty does not vanish merely because family size is small. That, in any case, is the experience of the poor. So they assume, and not without logic, that the larger the family the better its chances in coping with the environment of life. It is pointless to try to prove the poor wrong—for, insights into the logic of living are as open to them as to others. Rather, the value of a small family for enhancing the quality and meaning of life, must be seen by the poor in their own lives, for them to believe in it. This represents the unmet challenge to public policy in all the countries bulging with populations.

Experience has repeatedly shown that attempts to lower the birth rate cannot be separated from the basic needs of the people who account for the high rate—their needs in essential nutrition, basic education, primary health care, shelter and sanitation, and to sustain all these a social environment supportive of employment and equity. In this matrix of basic needs and services, the priority, in terms of time and value, belongs to the protection and care of children born and being born. The argument is experiential as well as ethical.

The equation between child deaths and childhood diseases on the one hand and births on the other is a permanent part of parental consciousness, yet it is weakly linked in the theory and practice of public policies. Seen in the aggregate and as peculiar to a class of people other than one's own, nagging intellectual doubts persist. For example: Fewer deaths make a population to rise, so how will further reduction stabilize the number? Even if it does, will it not take too long for the good of the process of development? For their part, the poor too are entitled to ask: What if deaths decrease, and births too, but not disease? The answers belong together; for, in the interplay of the many factors that affect child health and influence the fertility rate, one set of them cannot be isolated from the others.

In communities where child health has improved and infant mortality reduced, it has been easier to have birth spacing accepted. Longer intervals between births are the first step in the voluntary way to a small family. Birth spacing provides the breathing space for a couple to make up their minds. This is the time when public services and community support can demonstrate the familiar

message that the health of both child and mother will be better with fewer and well-spaced births. A change in parental perception is the foundation of policy success.

Recent studies in several countries show a close correlation between improved child health and a reduction in the number of births. Expectedly, the per capita expenditure on food decreases as the number of children increases. This apart, birth spacing has a positive impact on the duration of breast-feeding and the degree of maternal attention. The rates of infection are probably lower among children more widely spaced.

In a short birth interval, both the older child and the one born after face serious problems. The former is taken off the breast earlier, mostly because of the new pregnancy. Mortality is found to be much higher among those weaned ahead of normal time. A child born before an interval of less than two years is more likely to be malnourished than the child who was two or more years old before the next child was born especially in poor families. The child born after an inadequate interval is also not spared. Maternal depletion on account of short spacing probably explains the diminishing birth weight generally associated with higher order births beyond four or five. Intelligence scores too seem to be significantly lower in short birth interval groups.

A recent analysis by the World Fertility Survey in 29 countries found that children born after intervals greater than four years had less risk of mortality than those born after intervals of two years or less. These correspond to earlier findings by WHO studies in India and elsewhere. A Princeton University research covering some 25 developing countries reveals interesting results: If all births were spaced at least two years apart, infant mortality can be reduced by 10 per cent and child mortality (between one and four years) by 16 per cent, for this reason alone.

Arguments do not convince the poor, only a visible change in the context of their lives can. Policy makers who seek to promote the small family norm have a moral responsibility to give that child who is allowed to be born the maximum opportunity for full development. It is not enough to see that the birth rate graph comes down, but simultaneously interventions to prevent morbidity and

mortality of infants and children must go up and become part of the same programme as family planning. And the concept of health promotion must go beyond the health sector to meet the threat to child life from wherever it comes, be it maternal malnutrition, infectious disease, iodine deficiency or water pollution.

The process of improving child survival starts with the parents as much as the decision to have fewer births. Services in family planning and maternal and child care delivered to a passive community may not be the best way to optimal results. The "provider" approach neither gives the people the certainty that the present is secure, nor does it help to establish a link between current progress and future well-being, nor for that matter does it give people the confidence to intervene and control the environment of their lives. Whether the health and family planning services are rooted together in the community determines their durable success. Development—centered on the people and with a focus on maternal health, adequate attention during delivery, and the survival and protection of the child as its leading edge—is, perhaps, the best contraceptive.

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A FOCUS FOR HOLISTIC HEALTH

Statement by David P. Haxton
UNICEF Regional Director for South Central Asia
at the Indian Public Health Association
Annual Conference
New Delhi, 23 January, 1987

1. I am attracted by the central theme of your deliberations, namely, an inter-sectoral approach to maternal and child health care. As a professional association whose function is to improve the capacity and effectiveness of its members, you could not have chosen a topic of greater long-term potential for public health.

2. I say so because mother-and-child, as a single biological-and-social unit, is necessarily *the* focus for any organized effort towards holistic health. Also, improved health, as a human right, depends heavily on the integrative principles underlying the concept of primary health care. While these propositions have been widely accepted, progress on the ground towards them has been slow, at times problematic—with the bright exception of numerous locally successful projects. On a national scale, access to health care in most developing countries, is limited in effect to 15-20 percent of the population, mainly in the more affluent urban areas. A bold approach that gives priority to reaching the

people in greatest need awaits the renewed initiative of public health professionals. The climate for such social enterprise is, I would say, propitious. This is mainly because of the relatively recent coming together of several strands of health policy, of the organizational instruments for implementing it and increasingly of the channels of service delivery.

3. For example, for the first time, the responsibilities for promoting the small family norm and for ensuring the survival of children have been seen as mutually reinforcing and management of those delivery mechanisms has been strengthened.

4. This is to my mind, quite significant because contemporary history shows that the family planning and child survival belong together. If there are fewer deaths in the womb, at birth and during early childhood, there will be fewer births. This demonstrated relationship has been reinforced by recent research, the findings of which I need not recount here.

5. Again, the nexus between health policy and programmes on the one hand and scientific principles, technological options, and communication possibilities on the other has grown stronger than ever before.

6. The natural connections between several pairs of crucial factors are beginning to be recognized and acted upon : like, health and food supplies, nutrition and farm production, infections and environmental sanitation, improved communications and education, womens' education and their family responsibilities. Ways must be found to bring together this variety of concerns.

7. There is no technology or scientific principle involved in promoting maternal and child health that is not known or not available in India. Most of these options make relatively modest demands on financial resources. In these days of rapid means of mass communication, it is possible to reach the most important health workers, namely, mothers, including those who may be illiterate and in remote rural areas.

8. This constellation of favourable factors rests on solid foundations. As you know the public health infrastructure has been

built up into one of the largest anywhere. The vast network of primary health centres and sub-centres was started in the early 1950s mainly to promote maternal and child health. Over the past decade and more there has also been a parallel development involving major health related facilities to children and mothers. I am referring, of course, to the expanding Integrated Child Development Services (ICDS) now covering over a fourth of the country. In addition there have been, for some years, other national programmes of relevance to maternal and child health, like immunization, blindness prevention through vitamin A distribution, oral rehydration therapy for diarrhoea management, distribution of iron and folic acid tablets for anaemia during pregnancy and goitre control by iodinating edible salt. What is needed at this stage of development appears to be two-fold: *coordination* of related functions through organizational readjustments and *mobilization* of resources of many kinds through social communication.

9. The process of intermeshing diverse programmes implies collaboration and therefore functional coordination among them. Coordination of separate, sometimes competing institutions, agencies and experts becomes as important as mobilizing resources, knowledge, skills, personnel and enthusiasm, if universal access to health care is to be achieved.

10. At the same time, the need for concerted action is urgent, as the maternal and child health programme as a whole is yet to produce any spectacular change in the mortality rates of mothers, infants and pre-school children, or for that matter, in the population growth rate. The solutions for the massive health problems relating to women and children, who represent two-thirds of India's population, are known yet not within reach. The fairly high adverse national averages for most mother and child health indicators, in fact, conceal the even greater adversities facing mothers and children in the poorer half of the population in tribal areas, inaccessible villages and urban slums.

11. In 1985 there were nearly 200 million women and children below the poverty line. And this is the widely scattered group that is most susceptible to disease and most vulnerable to death. There are no reliable data or estimates on levels of morbidity, but

surveys indicate that less than 15 percent of children below five years may be in a normal state of nutrition. The remaining 85 percent suffer from varying degrees of malnutrition—32 percent from moderate, 48 percent from mild and 5 percent from severe forms of malnutrition. According to conservative estimates, around 40,000 children are turning blind each year due to vitamin A deficiency. Some 40 million people, more females probably than males, suffer iodine deficiency disorders. About 63 percent of the children below three years of age and 45 percent between three and five years and at least half the pregnant women suffer from iron deficiency anaemia.

12. I would describe the needed departure in mother-and-child health care as a *new ethic* for children. Let me try to sketch what I think should be its main elements :

12.1 *First*, we must accept the principle of *Children First*. This implies that mother-and-child health must be the first charge on our resources, as an investment in basic human development. This must be reflected in our political, economic and social priorities, in the use of our time, in the focus of our attention at the policy, planning, implementation, and evaluation stages.

Here I am glad to invite your attention to the recent SAARC Conference on Children which resulted in a clear definition not only of approaches to basic human development from the earliest childhood, but also of immediate priorities starting with the female child and the adolescent girl, proceeding through each stage of childhood right from conception and relating the process of change to the physical and social environment. This is but a renewed start yet it is a comprehensive prescription which I would commend to your professional attention.

12.2 *Second*, there is the need for greater *urgency and acceleration towards universal coverage* in positive and fairly simple interventions on behalf of children and mothers, like :

—protection and promotion of the practice of breast-feeding and proper weaning, through regulatory as well as awareness-building measures;

—the need to protect all the children against immunizable diseases through universal coverage, rather than protect a small number of them with only a marginal effect on disease prevalence in the community;

—the imperative to let mothers know that an appropriate salt-sugar solution, or rice water, can prevent their children from dying from diarrhoeal dehydration as they do today, literally in millions each year;

—the urgency to fortify food with iron or to consume inexpensive iron-rich natural foods in situations, such as of South Asia, where at least half the pregnant women and children of pre-school age are anaemic for lack of iron in the blood.

12.3 *Third*, there is the allied imperative of *simultaneity and convergence* of services or interventions for children. It is at this point of decisive action that the primary health care concept becomes relevant: the community-based approach, training of para professionals and community workers, professional back-up, organic linkages with the health and other service systems, social mobilization of resources, pressing into service all possible channels of two-way communication between health workers at all levels on the one hand and the community on the other—all this strengthened by strong political commitment and government support. If this be the overall scheme of the primary health care approach, all the elements of primary health care itself are affordable even for low-income populations and as effective as any tested alternative.

12.4 *Fourth*, the process of social change must have a firm *basis in the community*. There is need to shift to the centre of gravity of the design of health care (and other factors of development) from the professional elite to the under-developed community. This becomes feasible as soon as we recognize that mother-and-child health care is not the same thing as medical care for disease treatment. Maternity is a normal condition, not a rare medical problem. Likewise, immunization is for children who are well and a protection to health rather than a response to disease.

12.5 And *fifth*, the sharing of life-saving and life enhancing knowledge is a crucial element of a new ethic in relation to children. It

is this aspect of health promotion that the Alma Ata Declaration refers to as health education. In its broader connotation, it may be called development communication resulting in a *social learning process.*

13. A new ethic for children would depend for its success on what is sometimes called a *health development network.* It could build on existing strengths, assign a manageable range of responsibilities to local institutions, and co-opt all feasible channels of co-operation. The network could find local solutions through a learning approach based on an assessment of needs, resources and demands, with improved understanding of community based social change and culturally adapted methods of management.

14. You are among the leaders in the field of preventive health. Your contribution to eradicating smallpox has been decisive, as the presence of Padma Shri Dr. Sharma reminds us today. There is no reason why you cannot take the lead again and ensure that every child born and every woman who is pregnant is fully immunized, that every mother in the country is aware and skilled in managing diarrhoea or other childhood diseases, in the home.

15. As I suggested at your earlier meetings, a practical way of proceeding would be for each of your members to assume a specified responsibility for promoting mother and child health in a defined population group. You may like to choose districts or smaller units, based on a balance between the needs of the community and the professional resources you can deploy concurrently with other sources of support.

16. The means of success would be your coalition, for the common good, with voluntary agencies, business groups, religious bodies, the schools system, the public services network and the media. The measure of success would be the reduction in such telling indicators like the maternal mortality rate, incidence of still births and low birth weight and infant and child mortality rates. There is no reason why India cannot compress the time to bring these down to the impressive levels already attained by some parts of it.

As a matter of fact, there is no reason all countries cannot do it. It has been shown that political, technical and public support

is readily available in combination with mass communications support when a loud emergency strikes children. We must now pull those forces together to attack the silent emergency which faces children every day.

There is no reason why rapid progress cannot be made against the death and distruction of children from easily preventable causes. It should be, in our opinion, a matter of national shame if in the next decade any country has a majority of its children not fully immunized. It should not be acceptable that parents do not receive information to protect their children from dehydration through oral rehydration therapy at home.

Within ten years it is possible that virtually all parents should be informed and supported in the use of basic knowledge about birth spacing and prenatal care; about low cost ways of preventing and managing common childhood illnesses and about promoting sound physical and mental growth.

Within ten years, there should be no reason to allow one more child to be born a victim of iodine deficiency.

Within much less time all governments, along with the international community and its economic institutions, should have sought and found new ways of coping with economic setbacks to ensure that these are never translated into malnutrition and rising mortality rates of children.

The time to take the first step to these ends is now. The choice is ours.

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